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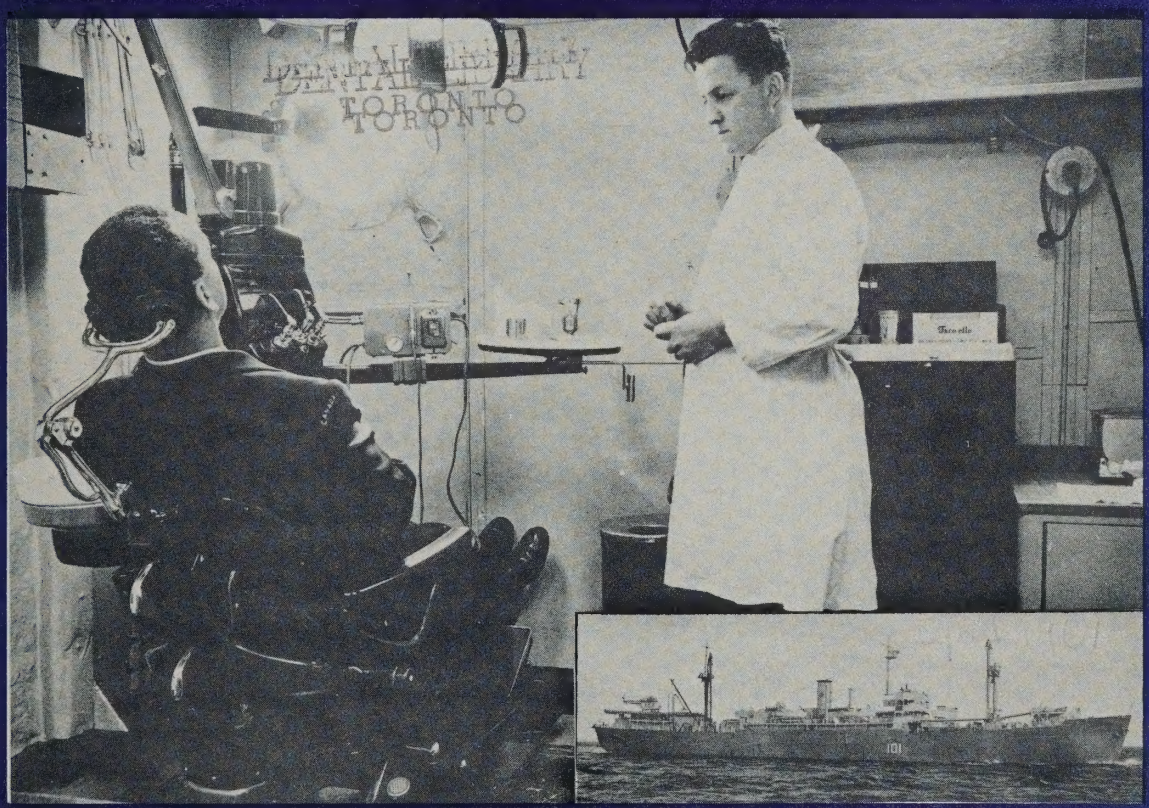
The ROYAL CANADIAN DENTAL CORPS Quarterly



NEW SUBSIDIZATION PLAN AUTHORIZED

Word has just been received that a new plan for subsidizing dental undergraduates for service in the RCDC has been authorized. This new plan replaces the Regular Officer Training Plan and the 21-Month Subsidization Plan and combines the best features of both. No further enrolments will be accepted in the old plans. Benefits provided include:

1. Up to 45 months (4 academic years) free tuition;

2. 24 months as an officer cadet with $63 per month pay and $65 per month allowance for food and quarters when these are not provided;

3. 21 months as a 2nd lieutenant with $225 per month pay and $75 per month allowance for food and quarters; or $375 per month pay if married;

4. Actual cost of dental instruments and supplies;

5. Annual grant of $75 for textbooks;

6. Enrolment is permitted at any level of dental undergraduate training;

7. Undergraduates enrolled in the ROTP or 21-Month Plan may transfer to the new plan.

8. No age limit is imposed except that an undergraduate must be young enough to complete the compulsory period of service following graduation before normal retirement age which is 47 for a Captain;

9. Undergraduates are permitted to be married after commissioning as a 2nd lieutenant.

10. A five-year period of service following graduation is mandatory. At the conclusion of this service the option is given to continue in the RCDC as a regular officer or be released to civilian life.

The points listed above are simply the highlights of the new plan. Many other benefits and privileges associated with military service and commissioned status are provided.

Interested dental undergraduates can obtain further information from their University Resident Staff Officers or write direct to:

Director General of Dental Services,
Army Headquarters,
Ottawa, Ontario.

Cover Photo

Sgt Doug Murley is shown with a patient in the dental clinic aboard HMCS Cape Scott (inset).

Cover Letter

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THE RCDC QUARTERLY

Published by authority of Brigadier KM Baird, Director General of Dental Services for the Canadian Forces

Editorial Board: Col GB Shillington
Lt Col JG Butler
Maj DH Protheroe

12 DENTAL COMPANY

Lt Col AT Roger, MBE, CD, DDS

For anyone interested in the military history of early Canada, a posting to No 12 Company RCDC(R) provides an excellent opportunity for on the spot investigation of historical events which occurred during the formative years of the region now known as the Atlantic Provinces.

The history of No 12 Dental Coy is relatively brief; however, as one of the original regular force companies it has seen a considerable number of changes take place in its establishment and area of responsibility. It might be of interest particularly to our younger members, to review in a few sentences some of the stages in the development of this unit to its present status. Shortly after the close of the Second World War three dental companies were formed to provide a dental service for Canada's peace-time forces. No 12 was designated as the "Navy Company" and soon a strong rumour was circulating to the effect that its personnel would shortly be changing from khaki to the navy blue of the RCN. Whether this was based on unfounded conjecture or high level deliberations is not known by the writer, however, it is certain that the unified corps which has evolved over the years is far preferable to three separate dental services, particularly for peace-time conditions with a continuing shortage of RCDC personnel.

The geographical area coming under 12 Coy jurisdiction originally extended all the way from the Quebec-Ontario border in central Canada to Newfoundland, Labrador and the three Maritime provinces in the east. During this period 12 Coy was responsible also for personnel aboard ships based on the Pacific coast.

As the need for dental service increased with the establishment of various new components of the three services, the situation was alleviated by the formation of No 15 Coy with headquarters in Montreal, 12 Coy retaining responsibility for the three Maritime provinces and Newfoundland.

The affairs of this unit have, since its inception, been guided by a series of illustrious commanding officers, the first of whom was the then Lt Col CBH Climo. On being posted to the Directorate, he was succeeded by the late Lt Col FJ MacLean. Lt Col WE Meldrum from the staff of the DGDS was next given command and he remained in Halifax three years until appointed Commandant of The RCDC School, then located in Ottawa. Brigadier KM Baird, then a lieutenant-colonel, was the next Commanding Officer, and he in turn was succeeded, upon his promotion to Colonel and posting to Trenton, Ont, by Lt Col HL Harris, previously CO of 13 Coy. After more than four years on the Atlantic coast Lt Col Harris was promoted and posted to the Directorate at AHQ. Lt Col WM Sinclair then was appointed Commanding Officer, remaining until his retirement in the spring of 1960.

Two of these gentlemen, Colonels Climo and Meldrum, on retirement returned to clinical dentistry and are at present augmenting the efforts of the Corps in the Ottawa area. Lt Col Sinclair has accepted a position with the Manitoba government and is now attending the University of Toronto to become qualified in Dental Public Health.

Over the years various new clinics have been established to meet the needs of changing service distribution and others closed when military establishments such as Camps Debert and Aldershot shut down. Existing clinical facilities are steadily being expanded and improved. As in other dental companies the main problem is the provision of personnel to man these facilities.

As would be expected, the majority of our clinics are situated at naval installations and the RCN provides a larger number of potential patients for our dental officers than the Army and Air Force combined. Postings within the unit provide opportunities for 12 Coy personnel to gain experience in the customs and methods of the three services.

Two new clinics which have been opened during the past 12 months are located in HMCS Cape Scott and at HMC Dockyard. The Cape Scott is a supply ship which accompanies the fleet on exercises and is equipped to make "on the spot" repairs when required. A compact but complete dental clinic has been provided, including laboratory and darkroom, and dental detachments are assigned from various shore establishments for the duration of fall and winter cruises. These usually include the coastal waters off Nova Scotia in the autumn and the Bermuda area during January and February.

The Dockyard clinic is strategically located "on the waterfront"; in fact it is on the second "deck" of a building which also houses repair facilities for ships, boats and other small craft. This is an extremely busy clinic, particularly when the majority of ships of the fleet returns from manoeuvres and the crews avail themselves of the opportunity to obtain dental care.

The clinic in HMCS Bonaventure includes two chairs and sections are posted on board for periods of approximately one year. A description of conditions on the aircraft carrier will be found elsewhere in this and previous issues of the Quarterly.

The Camp Gagetown detachment is another hard-working group and each summer arrangements must be worked out there for participation in, and dental service for the infantry brigade group concentration and exercise. During these few weeks of June and July there is an opportunity for dental personnel to familiarize themselves with the operation of a mobile dental van and the problems involved in its movement and camouflage.

The treatment carried out during this period is generally rather restricted as the troops are fully occupied with their training activities.

The clinic staff at the large naval training establishment at HMCS Cornwallis devotes the greater part of its efforts to rendering RCN recruits dentally fit for their initial tours of sea duty. This is no small task as the embryo seamen are undergoing intensive training and, once at sea, may be out of reach of dental relief for a considerable interval.

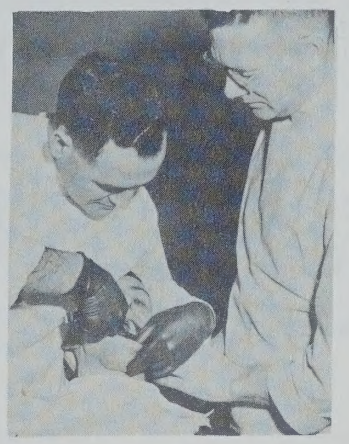
The sections with the RCAF at Greenwood, Chatham and Summerside also deserve mention for the large number of personnel on these stations provides ample work. However certain "fringe benefits" in these locations include opportunities for weekend "flips" to the Azores, Montreal or other glamorous spots.

The dispersal of various elements of the fleet, for refit and other purposes, to ports such as Sydney, Saint John and Shelburne poses a problem in providing dental care. We are fortunate in being able to utilize the services of our civilian confreres in these areas and comprehensive treatment is always available.

This unit also has a number of part-time clinics which must be attended at regular intervals, at such locations as Beaverbank, Moncton, Gander and St John's, Newfoundland. This additional commitment at times results in our available manpower being spread "pretty thin". However new surroundings and a change of scenery from time to time are a part of service life which most members enjoy, whether they will admit it or not. If nothing else, it provides opportunities to explor new fishing areas and this part of Canada is an ideal playground for addicts of this sport.

Our hunting enthusiasts, too, usually do not come home empty handed. Another popular pastime is sailing and facilities in this area are plentiful for all types of boating. Camping trips are becoming increasingly popular and opportunities for simply "admiring the scenery" are plentiful.

All things considered, life can be very pleasant in this Atlantic region and it is hoped that perusal of this article may prompt a few requests for posting to No 12 Company, RCDC.



12 Coy Personnel

Top - L to R - Capt Harry Meisner, Cpl EL Schell, Major Gord Grant, Sgt Doug Murley, Capt RJ Lewis

Centre - L to R - Cpl HD Wagstaff, Capt Denny Morrison and Cpl Wagstaff

Bottom - L to R - Cpl AF Randall, Cpl Larry Barrett, Capt Lewis, Cpl Randall, Capt Meisner, Cpl Wagstaff, Lt Col Norm Butcher, S sgt Alec McIsaac, Capt Morrison, Cpl Schell

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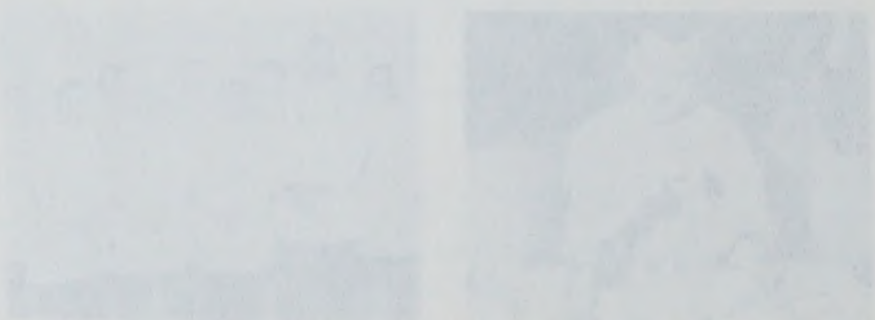


A Simple Method of CARDIAC RESUSCITATION

W. B. KOUWENHOVEN, DR. ING.,* JAMES R. JUDE, M.D.,**
and G. GUY KNICKERBOCKER, M.S.E.,*** Baltimore

DIGEST

Cardiac arrest results from a variety of causes, including anesthesia, anoxia, and myocardial infarction, and may occur when a patient is undergoing dental treatment. In circulatory arrest the heart may be either in asystole or ventricular fibrillation. When this emergency occurs prompt action is essential as the human brain can only survive three or four minutes without oxygenated blood. When the pulse disappears and the respiration ceases two measures must be effected: (1) artificial respiration, and (2) the circulation of the oxygenated blood. This article describes the procedure used to obtain cardiac resuscitation when an emergency arrest of heart activity occurs.

First Steps in Treatment

1. In treating cardiac arrest the patient must first be placed in a supine position, preferably on a firm support such as the floor or a table. If placed on a bed, a board should be placed under the patient's back.

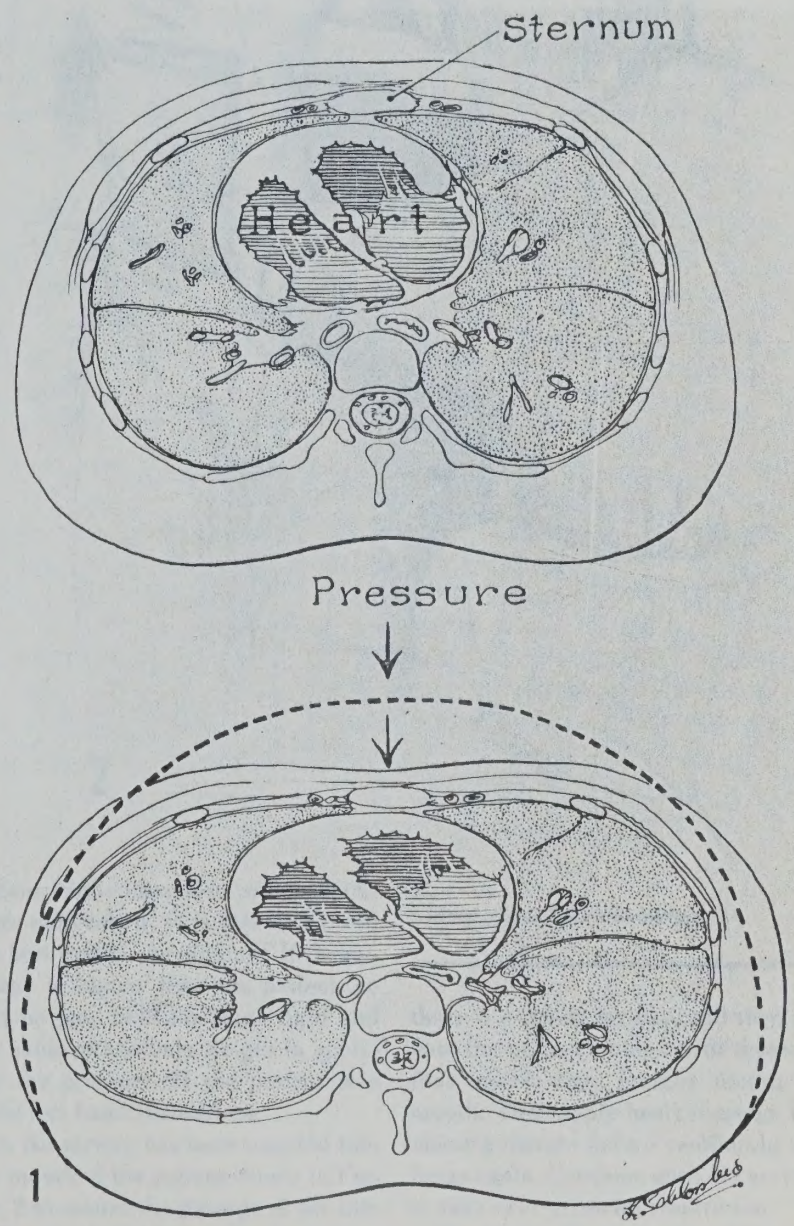
2. The chin should be raised, the neck extended as is done in the practice of mouth-to-mouth respiration.

3. The blood is circulated by applying closed chest heart massage. Heart massage and artificial respiration should be applied simultaneously. When these measures are in process an ambulance should be called.

Heart Massage—Definition

Closed chest heart massage[1] is a method of squeezing the heart by pressing on the breast bone. This provides adequate circulation to nourish the central nervous system and maintain the tone of the heart without resorting to thoracotomy.

Method—The manner in which the heart is squeezed by pressing on the breast bone is shown in Figure 1 which



1.
Cross section of chest.

is a cross section of the chest at the level of the lower third of the sternum. The heart lies between the sternum and the vertebral column and its lateral movement is restricted by the pericardium. The ribs are joined to the sternum by their costal-cartilages. The chest of a conscious person is rigid, but that of an unconscious person is remarkably flexible.

Blood Forced into Circulatory System—When the breast bone is depressed by the application of pressure, the heart is squeezed between it and the vertebral column and blood is forced out into the circulatory system. When the pressure is released the chest expands and the heart refills. The operation of the heart assures the circulation of blood when rhythmic pressures are applied to the sternum.

Steps in Procedure

1. Provide a patent airway.

2. Closed chest cardiac massage is applied by placing the two hands, one above the other, on the breast bone of the patient as illustrated in Figure 2. The cardinal points for the location of the hands are the xiphoid, at the lower end of the sternum, and the suprasternal notch at the upper end. The breast bone lies between these two landmarks.

3. The heel of the lower hand is placed on the lower third of the sternum, just above the xiphoid, and the other hand is placed on top of it. Firm vertical pressure should be exerted at the rate of 60 to 80 times per minute. No pressure is exerted with the fingers.

4. When pressure is released the hands may be lifted a fraction of an inch from the chest. Systolic blood pressures of 90 to 120 millimeters of mercury, and diastolic pressures of 30 to 50 millimeters are normally realized.

5. The operator may approach the patient from either side, whichever is more convenient. It is less tiring and the best results are obtained if the operator is higher than the patient, so that he may hold his arms rigid and use some of his body weight in applying the pressure. If the patient is a child one hand is sufficient.

6. An airway has been inserted into the mouth of the patient shown in Figure 2 to assure the passage of air into and out of the lungs by mouth-to-mouth artificial respiration.

Airway Must be Present—If there is only one operator available in the emergency, he should first be sure that there is a patent airway, and then inflate the patient's lungs with three or four quick deep breaths mouth to mouth. Then apply heart massage for about a minute before ventilating the lungs again. Continue until aid arrives to take over artificial respiration.

Signs of Resuscitation—The patient's condition may be observed during the application of massage and artificial respiration. The pupils should remain constricted. If they were di-

2.
Closed chest heart massage.

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**Resident Surgeon, Johns Hopkins University School of Medicine.
***Assistant, n Surgery, Johns Hopkins University School of Medicine.

Author's Note: This study was supported by a grant from the National Heart Institute, National Institutes of Health.

[1]Kouwenhoven, W. B.; Jude, J. R.; Knickerbocker, G. G.: Closed Chest Cardiac Massage, JAMA **173**:1064 (July 9) 1960.
[2]Kouwenhoven, W. B.; Milnor, W. R.; Knickerbocker, G. G.; and Chesnut, W. R.: Closed Chest Defibrillation of Heart, Surgery **42**:550 (Sept.) 1957.
[3]Kouwenhoven, W. B.; Knickerbocker, G. G.; Milnor, W. R.; Jude, J. R.: Field Treatment in Electric Shock Cases 11, Elect. Eng. **79**:500 (June) 1960.

lated before the start of resuscitation, they should constrict afterward. In some cases a patient may make attempts to breathe on his own. These signs indicate that the resuscitative techniques are effective. With effective heart massage a palpable pulse may be detected, especially in a femoral artery.

Effective Aid in Hypotension—In some instances of cardiac standstill this massage plus artificial respiration may be sufficient to cause the heart to resume autogenous beats. In other instances, including cases of ventricular fibrillation, the heart will not resume sinus rhythm and if massage is stopped spontaneous breathing ceases and the pupils dilate rapidly. Closed chest cardiac massage may also be used as an effective aid in cases of marked hypotension. It is not necessary to attempt to synchronize the massage with spontaneous cardiac activity.

Procedure Should be Continued Without Interruption—Both heart massage and artificial respiration should be continued in the ambulance on the way to the hospital. The hospital should be notified so that immediately upon arrival an electro-cardiogram may be taken and the nature of the arrest determined. If the heart is in fibrillation, it should be defibrillated with a closed chest defibrillator.[2,3] Supportive drugs should be administered as needed.

Efficacy of Technique Demonstrated—At Johns Hopkins Hospital where this report was compiled, in more than 50 cases of cardiac arrest, three out of four patients who received closed chest cardiac massage recovered to their former central nervous system status. The patients observed ranged in age from one month to 82 years.

Summary

When there is sudden loss of respiration and heartbeat, immediate action is necessary. If a few breaths in mouth-to-mouth artificial respiration are not sufficient to induce spontaneous respiratory and cardiac activity, there is no need to wait for further diagnostic attempts. Closed chest cardiac massage and artificial respiration should be applied at once. Because of the simplicity of this method anyone can now apply heart massage.

Johns Hopkins University
School of Medicine

Reprinted from the January 1961 issue of Dental Digest with the kind permission of the author, Dr. W. B. Kouwenhoven, Dr. Ing., and the editors of Dental Digest.

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BELL'S PALSY - REPORT OF A CASE

Capt FW Lovely, DDS

Bell's Palsy usually develops suddenly. There are several precipitating factors which include cold, infection and injury, but the primary cause is thought to be a vasonervorum disturbance. The mechanism is believed to be an anoxic edema of the nerve sheath brought about by a local vasoconstriction which causes swelling within the nerve sheath. The swelling is limited by the bony canal of the facial nerve, especially the constriction at the stylomastoid exit from the cranium. This limitation of expansion, accompanied by the anoxic edema results in a compression of the facial nerve causing a unilateral flaccid facial paralysis.

REPORT OF CASE

This case is not being reported to present anything new in the prognosis or treatment of this condition, but to serve as an aid in diagnosis and treatment, should a similar case appear at another dental clinic.

The patient, nineteen years of age, a normal, white, healthy male reported with gross caries of the lower left first and third molars with periapical involvement of each tooth. They were extracted with 2% xylocaine HCL, using a mandibular block, on 25 October 1960 and recovery was uneventful. On 14 November 1960 the patient reported with a left upper motor neurone facial paralysis.

The patient was referred to the Canadian Forces Hospital, Halifax for further treatment. On admission he stated that the palsy had taken about three days to develop. It could be seen on examination that the supraorbital, temporal and buccal branches of the facial nerve were involved since the patient could not elevate his forehead, forcefully close his eye or retract the corner of his mouth. Further examination revealed the patient had altered taste sensation in the left side of the tongue as a result of the affected afferent fibers which innervate the taste

buds of the anterior two-thirds of the tongue. There was no decrease in the tears of the left eye. Also evident was a wet herpetic type of rash involving an area of two inches in diameter on the left side of his chest which appeared to follow the distribution of the second thoracic nerve anteriorly. There was no other herpetic rash suggesting Hunt's Syndrome, which frequently accompanies Bell's Palsy and is characterized by a rash within the ear canal. Faradic stimulation to the facial nerve gave a normal response.

TREATMENT

The patient was given 25 mgm. of cortisone q.i.d. for two days and infra-red heat therapy to the left side of the face twice daily for twenty minutes accompanied by physiotherapy to facial muscles. After two days there was some improvement and the cortisone therapy was reduced to 25 mgm. t.i.d. for one day and then 25 mgm. b.i.d. until a total of 350 mgm. of cortisone had been administered. There was gradual improvement until 22 November 1960 when all facial muscles showed normal movement, at which time the patient was discharged from hospital. Weekly examinations following discharge revealed no recurrence of symptoms.

DISCUSSION

The etiology of this attack of Bell's Palsy is very obscure, since the patient did not give any history of exposure to extreme cold or drafts and there was normal healing of extraction sockets with no remaining infection. The paralysis occurred seventeen days following nerve block and exodontia, which, it is interesting to note, is the average incubation period for a virus. It would appear that this attack of Bell's Palsy had no connection with the exodontia which preceded its appearance.

SUMMARY

A case of Bell's Palsy such as this, appearing subsequent to dental treatment could cause a dentist considerable concern. The general opinion was, however, that the attack occurred at a period when the patient had a lowered systemic resistance and was accompanied by an attack of herpes zoster affecting the anterior branch of the second thoracic nerve.

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1. Mead, S.V. Oral surgery, 4th ed. p. 1029.

2. Grant, J.C.B. A method of anatomy, 5th ed.

3. Sicher, Harry Oral anatomy, 2nd ed.

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AMALGAM .... had an unfortunate beginning. In 1833 the Crawcour brothers arrived in in this country from France with their "royal mineral succedeneum" which they advertised for filling cavities with the least pain. While worthy dentists sat idle, the Crawcour brothers literally did a "land office business." It is said they did not excavate the cavities, merely pushed the filling material into place, and if no cavities were present, inserted the "royal mineral succedeneum" into the interstitial spaces. The wrath of the patients and that of reputable dentists prompted their departure from this country.

S.S. White Dental Manufacturing Co., "Early Amalgams," A Century of Service to Dentistry 1844-1944 (Philadelphia: S.S. White Dental Manufacturing Co., 1944).

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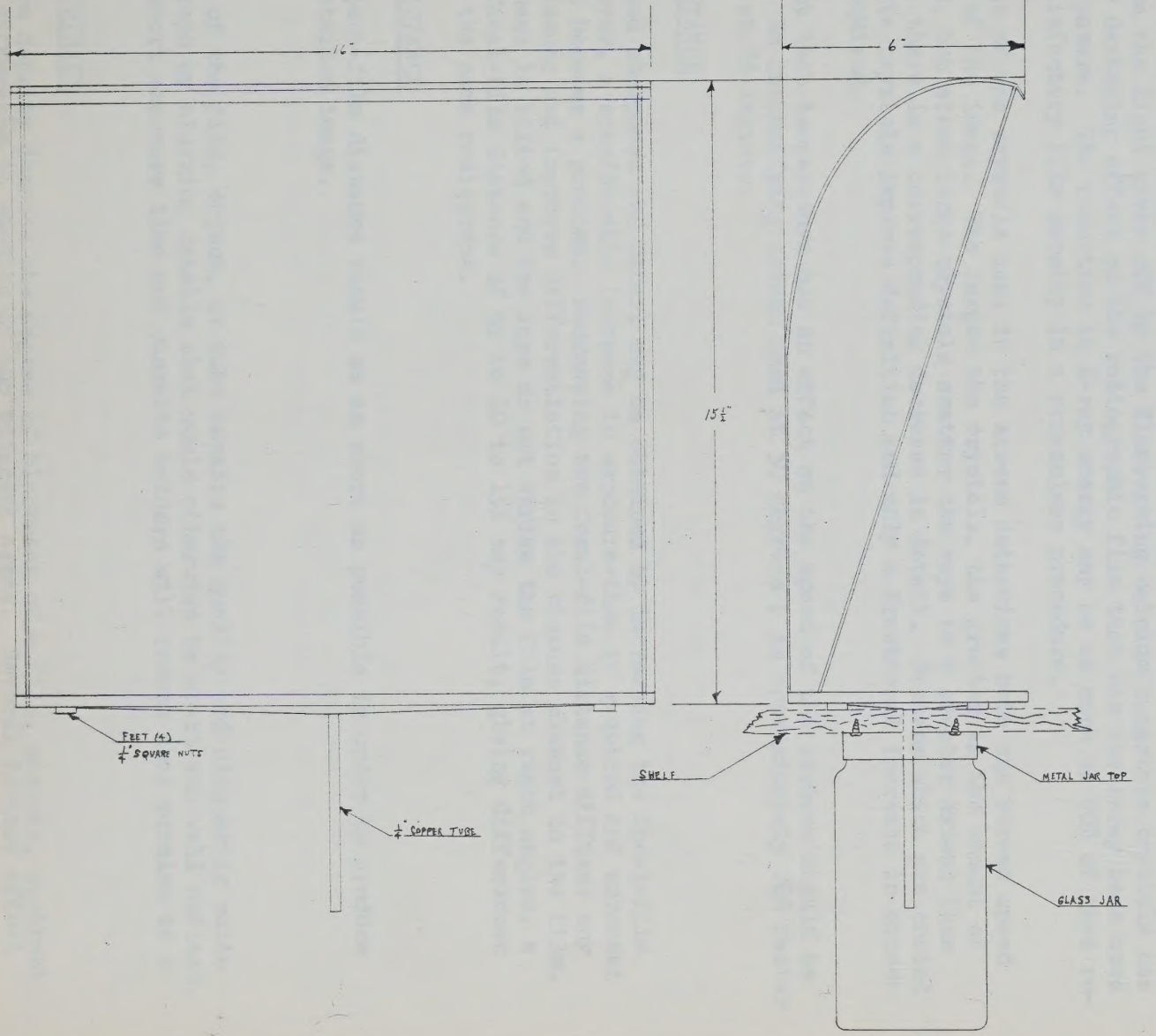
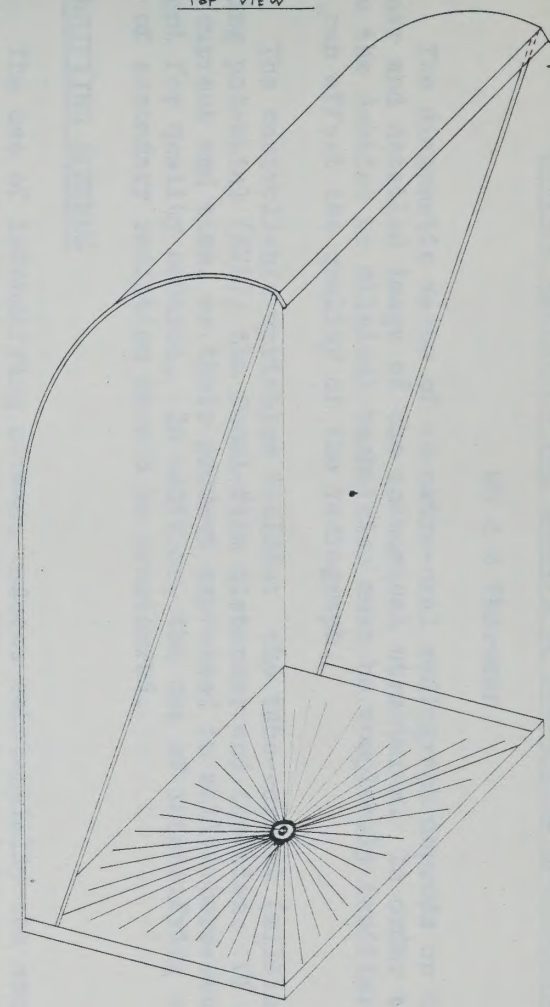
FRONT VIEW

END VIEW

TOP VIEW





STEAM COLLECTOR FOR STERILIZER

MATERIALS USED: STAINLESS STEEL

DRAWN BY W D. MORRIS

DESIGNED BY W.D. MORRIS

FACTORS AFFECTING THE QUALITY OF EXTRA-ORAL RADIOGRAPHS

WO 2 H Thorsson

The diagnostic value of an extra-oral radiograph depends on the production of a clear and detailed image of the anatomical structures. In order to obtain such an image the dentist or clinical technician must be completely familiar with the variables that can affect the quality of the radiograph.

The controllable variables include: the tube-current (milliamperes); the accelerating potential (KVP); the focal-film distance; and the time. Of these, the use of tube current and time, or their product expressed in milliampere-seconds, is most convenient for quality control. In addition, the use of intensifying screens and the problems of secondary radiation should be considered.

INTENSIFYING SCREENS

The use of intensifying screens reduces substantially the amount of radiation required, since the light given off by the fluorescing calcium tungstate crystals has a much greater darkening effect on the radiographic film that has the X-ray beam used to make the exposure. The reduction in X-ray energy may be as much as 90% of that required for satisfactory film density in a screenless procedure.

The size of the crystals used in the screen determines both the screen speed and sharpness of the image. The larger the crystals, the greater is the amount of light produced, but since large crystals scatter the rays to a greater extent than do small ones, there is a corresponding decrease in detail. Screens which are coated with very minute crystals improve definition and only a fractional increase in exposure time is required.

The fact that temperature has an effect on the speed of the screens should be kept in mind. An intensifying screen used at 50 degrees F is approximately 20% faster than one used at 75 degrees.

FOCAL-FILM DISTANCE

Increased sharpness and detail may be obtained by increasing the focal-film distance, however, a considerable increase in exposure-time is required and movement of the patient becomes a problem. Decreasing the focal-film distance diffuses any intervening tissues and improves differentiation in the tissues closest to the film. If the X-ray head is tilted and the rays do not strike the film at right angles, a variation in focal-film distance of up to 10 to 15% may result, giving differences in density in the same radiograph.

OBJECT-FILM DISTANCE

The object-film distance should be as short as possible in order to produce a sharp and detailed image.

MOTION

Motion of the film, object, or tube impairs the quality and diagnostic value of the radiograph by blurring details that would otherwise be sharp and well defined. The use of a short exposure time and cassette holders will reduce this problem to a minimum.

DENSITY AND CONTRAST

The term density denotes the degree of blackness of a film, whereas, contrast refers to the difference in shading of two adjacent areas. Several factors affect

density and contrast, but these qualities can normally be controlled through the tube voltage or KVP. The shorter wave-lengths of the X-ray beam are the most effective and the least damaging to the tissue and since these wave-lengths are determined by the voltage applied to the tube, it becomes apparent that the relation of wave-length to applied voltage is most important. An increase in the tube voltage (a) decreases the wave-length of the X-rays; (b) increases the intensity of the rays; and (c) decreases the absorption of the rays in interposed tissue.

MILLIAMPERE-SECONDS

Density of the film increases in approximate proportion to the increase in milliamperes (or tube current) and exposure time. When the milliamperage is increased the exposure time must be decreased to produce the same value: e.g., 10 milliamperes for 1 second and 15 milliamperes for 2/3 second result in the same film density.

Exposure time affects the overall film density to a greater degree than it affects contrast. Over-exposure and under-exposure cause too great and too little density respectively, and in both cases the contrast is decreased. When the exposure time is increased and the KVP decreased to diminish the density, there is an increase in contrast by reason of the longer wave-length of the rays and their greater absorption in the tissues. There is less detail, however, and the longer wave-lengths are more damaging to the tissue and skin.

SECONDARY RADIATION

Since secondary radiation has an adverse effect on density, contrast and sharpness of detail, it is most important that its causes and means of control are understood. Just as the primary beam is produced by the impact of electrons on the target or anode, so secondary radiation arises when the primary rays strike interposed tissue. There are two main types of secondary radiation: - scattered and characteristic. The rays of scattered radiation travel in all directions from the points of impact, while the quality of characteristic radiation is determined by the type of tissue through which the primary rays travel.

Secondary radiation can best be controlled by limiting the area of exposure to the absolute minimum required for diagnostic purposes. This is accomplished by using suitable cones and diaphragms and the correct focal-film distance.

* * * * * * * * * * * *

THE CASE FOR REPLANTATION

Major DE McDermott, CD, DDS
and Capt WF Shaw, BSc, DDS

The principle of replantation is certainly not new. Articles on replantation have been found in nearly all of the old and ancient writings of the dental profession. However, even though casual knowledge of the principles of replantation is prevalent amongst members of the profession, our experience has seen little of its actual practise.

As in any operative procedure the patients selected must be thoroughly screened so as to be certain that their oral condition warrants the contemplated operation. Patients especially susceptible to caries, with many missing teeth or with unhealthy gingiva, those in poor general health and those who, even after explanation, are not emotionally prepared to undergo this procedure, are unpromising cases. Also the tooth so evulsed must be suitable for replantation. There must be no acute pathological condition present in the host site. The therapeutic use of antibiotics systemically and locally in the host site no doubt has contributed to the reported success in many cases of replantation.

Grossman states that the tooth should be replanted as soon after its separation from the socket as possible since the prognosis is unfavourable if too long an interval elapses between the time of the accident and re-insertion of the tooth in the socket. He lists several points preparatory to the actual insertion of the tooth. These include thorough washing of the tooth, followed by a hydrogen peroxide bath; complete removal of pulp tissue; irrigation of the canal with an antiseptic and filling in the usual manner with a gutta percha cone. Excess gutta percha protruding through the apical foramen should be removed with a hot instrument and the root tip shortened and made smooth with sandpaper discs. Under anesthesia the tooth socket is curetted and the prepared tooth is replaced in its socket where it is supported by a splint or is ligated to adjacent teeth. Splints or ligations are removed after two or three months.

To date our experience has been limited to four cases of replantation. All but one have been successful. The reason for the failure of the one case is stated in the case reports. The replants are firm. It is noteworthy that, within one week of insertion, the gingival tissues were normal or almost normal. They were pink in colour, firm in texture, knife-like in contour interproximally, and had the stippling found in normal gingiva. Post-operative discomfort was minimal. In fact, the normal post-extraction tenderness was not present in all four instances; this was probably attributable to the following:

1. Lack of exposed bone.

2. Blood clot having a nidus (the replant) to adhere to and therefore not likely to be dislodged.

3. Adaptation of the gingival tissue to the smooth surfaces of the replant which has no local irritating factors.

Roentgenograms taken 6 to 8 weeks after insertion show that a substance resembling bone forms about the apex. The hope that blood clot, organization of clot, osteoid formation, calcification and mature bone would ensue appears to be supported by roentgenographic observation.

Cosmetically the replants are excellent. There is good stability of colour and functionally they have served well.

The following case reports illustrate some of the pitfalls encountered and some of the modifications to current techniques that were apparently advantageous, although basically the technique described by Dr. Louis I. Grossman was adhered to.

The first case which was attempted was unsuccessful. In describing it, some of the errors will be pointed out. The patient was an exchange pilot from the USN, flying jets in HMCS Bonaventure. He presented at the clinic one morning with his upper left central in his hand, the socket freshly bleeding. This was shortly after the CDA Convention in Halifax where Dr. Hare of the University of Toronto presented a paper in which he described the replantation of six teeth in the same patient successfully. So, encouraged by his success, it was decided to replant the tooth.

The first error, which was not immediately obvious, was that after refilling the root canal and curetting the tooth socket, the replant was too securely ligated in position. This placed the tooth in slight traction thus not allowing normal healing to take place. Another mistake was in the selection of the patient. He removed the acrylic splint after 24 hours without advice, then during recreational activities in the wardroom, was hit in the mouth and the tooth was displaced incisally.

This experience enabled a more realistic approach to the next case and it was decided to adhere to the following points:

1. Proper Selection of Patient

Although the age of the patient is very important, the most important factor is co-operation. The patient must really want to keep the tooth.

2. Tooth Treatment and Sterilization

The root canal must be opened, thoroughly cleaned, filed, irrigated and filled, preferably with gutta percha points as these can be sealed with a warm instrument at the apex.

The "sterilization" of the tooth should be by simply wiping with 3% Hydrogen Peroxide, or as second best, alcohol. The latter tends to dehydrate the cementum, which might interfere with union. Some periodontists have found that the presence of bare dentine stimulates the production of new cementum. With this in mind some gentle scaling of the surface of the root, exposing some dentine but not removing all the cementum, could be tried.

The tooth should be shortened about 1 - 2 mm at the apex. This reduces the hydraulic effect of seating the tooth and provides an area for new bone at the apex.

3. Preparation of the Socket

The socket should be curetted and irrigated with 3% Hydrogen Peroxide, to remove any clot debris. The walls of the alveolus should be freshened so that they are bleeding freely when the tooth is implanted.

4. Ligation

The tooth should be ligated in place firmly, but not too tightly. The ligature should extend mesially and distally the extent of two teeth and be placed under the height of contour, except for the replanted tooth, where it should be in the supra-bulge area exerting a retentive action on the implanted tooth. Kadon should then be painted into the embrasures to lock the ligatures in place. Further, Kadon should be painted on the lingual of other than the implanted tooth to remove the tooth from function. The Kadon should be left in place for about 1 month and then removed with a scaler. The ligature, if still functional, should remain an additional 2 weeks. To leave the ligature too long in place can reduce the favourable prognosis by keeping the implanted tooth too long out of function. The contention here is that the subsequent refunction of the tooth tends to stimulate the periodontal membrane thus decreasing the mobility.

The case of Pte T.P.Y. is cited next. He presented on 16 Sep 60 with an evulsed upper left central. Using the preceding technique the tooth was replanted. Ligatures were removed on the 20th of October and a radiograph taken. The tooth was firm and asymptomatic. Subsequent follow-up examinations as late as 11 Jan 61 showed the tooth completely functional with no signs of resorption. This case is considered a success, although it has not yet stood the test of time.

Replantation has been successful in each attempt since the first unfortunate but educational case. In addition to retaining a functioning tooth, it is thought to have other advantages:

1. It takes far less time than replacing the tooth with a bridge or partial denture when laboratory procedures are considered.

2. The prognosis compares favourably with a bridge or partial denture.

3. It develops a good dentist-patient relationship.

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REMINISCENCES OF IRELAND

S sgt PAA Egan, CD

We set out from London, England one August morning for the trip to Ireland boarding the "Irish Mail" at Euston station bound for Hollyhead, North Wales. This famous train was the first in the world to be referred to by an official name. From Hollyhead we crossed the Irish Sea via the British Railways' steamer "Hibernia", landing at Dun Laoghaire the same evening.

We spent seven days in Dublin, a fascinating city, seeing as many of the highlights as possible. Notable among these was Trinity College, founded in 1591, the library of which is of great interest. One of its most famous possessions is the Book of Kells, an illustrated manuscript of the Gospels dating from about the eighth century and generally considered to be the world's most beautifully illustrated book. Other interesting places architecturally were Christ Church Cathedral and St Patrick's Cathedral, founded in the eleventh and twelfth centuries respectively.

On a more mundane level were the Irish Sweeptstake buildings and the Guiness brewery. At the latter we followed the brewing of Stout through all its stages and after the two-hour tour we welcomed the refreshments which were supplied gratis.

Another interesting institution was the Abbey Theatre. It first opened its doors in December 1804. By 1807 "The Abbey" had achieved international fame. Among the well-known dramatists of the Abbey group are W.B. Yeates and Sean O'Casey. Unfortunately, this theatre was destroyed by fire in July 1951 and only the shell remains. Up to 1954 the Abbey productions were staged in the Queen's Theatre, Dublin.

From Dublin we toured county Wicklow, visiting Glendalaugh and Avoca, and as I had always wanted to see Galway and more particularly Galway Bay, we crossed Ireland via Tora and the Curragh, visited Galway and toured Connemara and Mayo. Incidentally we didn't find Galway Bay all we expected it would be.

For the second half of our leave we made our headquarters in Cork City. From Cork it is only a short trip to Blarney, where we had the opportunity to kiss the famous stone, although this was a risky business. After climbing the two hundred winding stone steps to the battlements of the castle, we had to hang suspended head first (grasping an iron railing) from the parapet of the battlements in order to kiss the stone and thus acquire the gift of eloquence.

We also toured the counties of Cork and Kerry, visiting Tralee, Killarney and Glengariff. Unfortunately time was running out and the many other points of interest will have to wait until our next trip, which we hope will be in the not too distant future.

The return to England was made on board the "Inisfallen" from Cork to Fishguard, South Wales and thence by train to London.

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BILATERAL SUBLUXATION OF THE TEMPOROMANDIBULAR JOINT

Capt ES Morrison, BA, BSc, DDS

In order to get a clearer picture of the condition known as Bilateral Subluxation of the Temporomandibular Joint, it is necessary to be familiar with the pertinent anatomy. This joint is a ginglymo-arthrodial, or gliding-hing joint. The two osseous parts are the glenoid, or mandibular fossa and the condyle of the mandible. The glenoid fossa is bounded anteriorly by the articular eminence and posteriorly by the tympanic plate of the petrous portion of the temporal bone. The temporomandibular joint may have various shapes and still be normal. Its movements are: (1) depression; (2) elevation; (3) protraction; (4) retraction; and (5) lateral excursions. The essential muscles involved in these movements are: (1) temporal; (2) masseter; (3) internal pterygoid; (4) external pterygoid; (5) mylohyoid; (6) geniohyoid and (7) digastric.

The T.M. joint is innervated by the auriculo-temporal and masseteric branches of the mandibular nerve. It receives its blood supply from the superficial temporal branch of the external carotid artery.

The two bony components of the T.M. joint are held in place by the capsular, temporomandibular, sphenomandibular and stylomandibular. It is injury to these ligaments, particularly the capsular ligament, that results in pathological changes.

The joint is divided into superior and inferior parts by an articular disk, known as the meniscus which is attached to the capsular ligament. Both parts of the joint are lined with a synovial membrane.

Normally the condylar head glides forward onto the articular eminence when the mouth is opened. In the fully-open position the condyle rests opposite and below the crest of the articular eminence. Any further movement of the condyle anterior to this point is considered abnormal, and usually results in dislocation of the temperomandibular joint. There are two types of dislocation, subluxation and luxation. Subluxation of the T.M. joint is usually defined as a self-reducing incomplete dislocation. The term luxation is commonly reserved for those cases of complete dislocation which require manipulation to reduce the condition. Only subluxation of the temporomandibular joint will be considered in this article.

This condition is a common source of facial pain, although pain may be absent. Clinically, subluxation of the T.M. joint may be diagnosed by digital palpation of the condyles while the patient opens and closes his mouth. The movements of the condyles may be accompanied by "clicking" noises and the patient's mouth may appear to literally fall open. Radiographically the head of the condyle will appear anterior -- but not usually superior -- to the articular eminence.

The treatment of any condition is governed, to some extent at least, by the cause. Similarly, in treatment of subluxation of the T.M. joint, local causes such as malocclusion should be eliminated. To demonstrate specific treatment for this condition the following case report is presented:

CASE REPORT

History and Clinical Findings

The patient concerned was an 18 year old male. He enlisted in the RCN, and was sent to HMCS Cornwallis to undergo New Entry training. It was noted during dental examination for Condition on Enrolment that his mandible became dislocated when the mouth was fully opened. However, the patient had no pain or discomfort of any kind and the mandible returned to its normal position upon closing the mouth. This condition had existed for about a year. About 4 or 5 weeks later this man reported to the dental clinic complaining of pain in the T.M. joints. He also reported that his jaw fell out of place when he was tired. The case was diagnosed as bilateral subluxation of the temporomandibular joint. At this time the patient was fitted with a headcap and chin support and warned about opening his mouth too widely. This form of treatment did not prove successful. About one week later at night he reported to the medical sick bay with a complete dislocation of the mandible. The patient had fallen in his living quarters and received a blow on the head. He was not wearing the headcap at the time. The dislocation was reduced by manipulation.

The patient's past history showed two serious head injuries at the ages of 6 and 8 years respectively. Deciduous teeth were extracted under general anaesthesia around 6 years of age. He suffered a fractured nose at about 12 years of age and again at 16 years of age he was knocked unconscious. The patient stated, however, that he was not aware of his jaw becoming dislocated after any of these injuries. He attributed the condition to holding his mouth open too wide and too long during dental procedures. It was after this experience, about a year ago, that he noticed his jaw "coming out of place". It was painful at first, but soon became asymptomatic, except for "clicking" noises.

Treatment by Injection

It was decided to treat this case by injecting both T.M. joints with a sclerosing solution, 5% Sodium Morrhuate. In this particular case the operation was performed in the "plaster room" of the hospital. The patient was premedicated with 75 mgms of Demerol to reduce pain and relieve apprehension. He was allowed to remain on a hospital carriage in the supine position. The area overlying both T.M. joints was prepared by shaving and then swabbing with an antiseptic solution. The skin of the area was infilitrated with 2% Xylocaine Hydrochloride containing Epinephrine 1:100,000, using a regular dental syringe. A 10 minim luer-lok syringe was loaded with 2% Xylocaine Hydrochloride without Epinephrine and a 21 gauge needle was attached. It was then carefully inserted until the T.M. joint was entered and using the aspiration technique, 4 minims of the 2% Xylocaine were injected into the right T.M. joint. Leaving the needle in place the syringe was removed, replaced with a syringe containing 5% Sodium Morrhuate and 4 minims of this solution were injected. Next the left T.M. joint was injected using the same technique. It was felt that the left joint was entered more readily than the right.

Post-operatively Demerol 75 mgms q.4.h. was prescribed to control pain. The reaction to the sclerosing solution was very painful. The patient was put on a high protein, minced diet and the headcap was replaced to restrict mandibular movements. Hot compresses were also applied regularly to the area of the T.M. joints.

For the first 24 hours the patient had severe pain which was effectively controlled with Demerol. The pain was more severe on the left side and for a couple of days the patient had difficulty articulating his posterior teeth.

Results

The tenderness in the T.M. joints subsided about one week after the operation, at which time, both left and right T.M. joints were normal. The patient could not force the condylar heads past the articular eminence and there was no restriction of movements of the mandible. This was demonstrated both clinically and roentgenographically. On examination, about 6 weeks post-operatively, both joints were functioning normally. After another few weeks the capsule of the right T.M. joint was loosened so that there was a "clicking" noise without dislocation. It was considered that the right joint should be re-injected. The patient was happy with the result of the first operation, and so is willing to undergo the second one which has not been done as yet.

Conclusions

Subluxation of the temperomandibular joint can be treated successfully by injection of a sclerosing solution, such as Sodium Morrhuate, into the joint. This operation can be performed relatively painlessly and post-operative pain can be well controlled by the use of anodynes. The joint can be returned to normal function without danger of residual damage.

The degree of reaction to the sclerosing solution seems to be indicative of the success of the operation. In this case there was more pain on the left side and a better result was obtained on this side than on the right. The injection may be repeated safely until symptoms of subluxation disappear and the operation may be performed in the standard dental chair.

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LET'S KEEP THEM IN SCHOOL

Lt Col NA Butcher, CD, DDS

Parents must assume the full share of responsibility for the education of their children, for the education they receive in this fast-moving world of today will greatly influence their happiness and success in the world of tomorrow.

A few years ago a person was considered adequately educated if he completed Junior Matriculation. Parents who harbour this opinion today are not keeping abreast of the times because Junior Matriculation is no longer adequate in many fields of employment and will be much less so a few years hence.

Each year thousands of young Canadians leave school to enter the world of work unprepared to meet even the minimum requirements of industry. A recent Department of Labour survey reveals that 70 per cent of children are now leaving school without Junior Matriculation or its equivalent, a level of education many industries demand today for training positions. If this rate continues, it means, according to 1957-58 figures, that 270,000 of the 398,000 students who enrolled that year will drop out of school before reaching this level. These young people will be forced, in most instances, to seek unskilled or semi-skilled jobs which usually present little in the way of career possibilities.

Only 30 per cent of all the jobs in Canada fall into the semi and unskilled categories and the educational demands of industry are lowering this percentage further. Where are the other 40 per cent of this huge body of former students going to be employed? Surely these hard, cold figures show that parents must do their best to keep their children in school as long as possible.

What Can Be Done?

There are several ideas that might be advanced. First, the child must be guided into the educational system from the time he starts to talk and think for himself. A child is a mimic; the care parents give to speech and mannerisms, or the lack of care, will be reflected in the child. Parents must show continued interest in the child's progress in school, and encourage him in his efforts.

Second, parents must be familiar with the educational systems. These vary greatly from province to province, city to city and town to town. It does not take long to determine why a child must study phonetics or why a high school student must take the prescribed language courses. Teachers are dedicated to the education of children and are only too willing to help the parent understand the educational system. A look into the mechanics of the local educational machinery should prove enlightening, interesting and beneficial.

Third, parents should respect the teacher's responsibilities. The parent who eagerly awaits the day he can dump his child into kindergarten and then feels his job is done is not only fooling himself but doing untold harm to the child.

Parents are very quick to criticize, but are slow to help and seldom thank the teacher for doing the job for which parents are partly responsible. Paying taxes does not give parents the right to shift the complete responsibility for educating their children onto the teachers. Home interest and help is essential and the teacher must be assisted by understanding and interested parents.

Fourth, interested parents will become familiar with adult educational facilities and avail themselves of opportunities to increase their own education. It is estimated that 7,000,000 adult Canadians have never finished high school. There is an ever-increasing demand for adult education classes; some are being provided by the schools, others sponsored by industry. The benefits derived from participating in adult education schemes will improve the parent's education, encourage other adults to participate, and set an example for the children.

Finally, parents must do all they can to help raise the educational standards. This may seem like a rather large order for an individual but a group of interested parents together can accomplish much. The Home and School Association with over 300,000 members is making a steady effort to raise standards. Parents should take their places on school boards, and do all they can locally to help improve education.

To summarize, parents must assume some responsibility for the education of their children, who in their adult years are certain to appreciate the interest taken in their education welfare. This responsibility includes: encouragement at an early age; knowledge of educational standards and procedures; participation in adult education; respect for the teacher's position; and efforts to help raise Canadian standards of education. The future citizens of Canada deserve all the education they can absorb. Let's keep them in school!!

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A TECHNIQUE FOR APICOECTOMY OF ANTERIOR TEETH

Major IW Susser, BSc, DDS, LDS

Apicoectomy and periapical curettage are considered to be a necessary part of the endodontic treatment required to retain a tooth when radiographic examination reveals a relatively large apical area of rarefaction.

Pre-operative treatment in such cases consists of a prophylactic dose of penicillin (500,000 units of Penicillin V orally t.i.d.) and antihistamine (Chlorpheniramine - 4 mgms t.i.d.) 24 hours before commencing treatment.

The treatment is carried out in two phases: (1) root canal filling; and (2) root resection and periapical curettage.

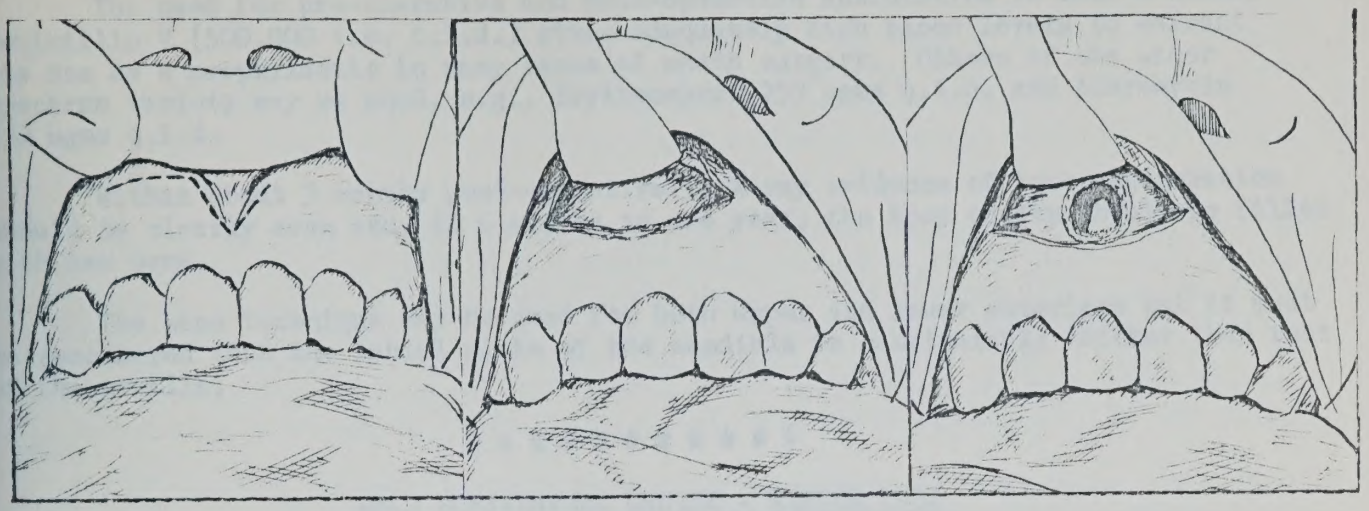
Phase 1 - Root Canal Filling

The tooth is isolated with a rubber dam and the canal is opened, filed, flushed with Hydrogen Peroxide 3% and Sodium Hypochlorite solutions and then dried. A Gomco aspirator with a sterile luer-lok needle (gauges 20-22) inserted into the canal will hasten drying. The canal is obliterated with a silver point of proper size and Kerr Sealer or with several gutta percha points liberally buttered with Kerr Sealer and condensed laterally with a Kerr #3 spreader. The pulp chamber is filled with gutta percha or cement.

Phase 2 - Root Resection and Periapical Curettage

A large pad of sterile gauze is placed between the teeth and the patient is instructed to bite on it throughout the operation. The field is carefully swabbed with 3% iodine and a straight line incision is made at the muco-labial fold extending over the roots of the adjacent teeth. It may be necessary, when treating central incisors to outline the base of the frenum with the scalpel and detach it to provide more access. The frenum can easily be sutured back to place at the end of the operation (Fig. 1). The soft tissue is elevated superiorly and inferiorly, opening the straight line incision to an elliptical shape. The superior tissue is held back with a retractor or large periosteal elevator (Fig. 2).

Moderate pressure and a slowly revolving bone bur are used to punch a hole through the labial plate into the pathological area. A granuloma or cyst will often erode the labial plate to almost paper thinness and in such cases the bur will practically fall into the cavity. The window is enlarged with rongeurs or a well irrigated bone bur until the apex of the tooth is completely exposed and access is provided to all pathological tissue around it. (Fig. 3).



(Fig. 1) (Fig. 2) (Fig. 3)

Root resection may not be necessary if there is sufficient access to allow the removal of all pathological tissue. It is indicated, however, where access is blocked by the apex of the root or where a cyst adheres so firmly to the apex that it cannot be removed in toto.

When the bony cavity is completely devoid of pathological tissue the cavity is dusted with penicillin G powder and the incision is closed with 3 to 4 interrupted silk sutures.

If the operation has been performed under strictly aseptic conditions and all diseased tissue has been removed, the blood clot under the flap remains sterile, undergoes organization and finally bone is regenerated around the root end. The incision, under these circumstances, usually heals by first intention and sutures can be removed in about 5 days.

The patient is given Penicillin V and Chlorpheniramine for two days post-operatively.

Discussion

It has been noted that the straight line incision at the muco-labial fold will heal very rapidly, leaving a scarcely visible scar even when the lip is retracted; whereas the U-shaped incision advocated in many texts, leaves a rather unsightly crescent which is plainly visible in patients with a high lip line. It has also been noted that, in most cases, the apices of the anterior teeth lie in line with or above the muco-labial fold.

It is advisable to leave as much as possible of the apical portion of the root in order to give better support to the tooth. In later years, when the paradontium recedes, one will be grateful for the extra root length. Nature takes care of any rough or sharp edges which may be inadvertently left in curetting the exposed root surface. There is no need to resect to the very base of the bony cavity.

Use of pre-operative and post-operative chlorpheniramine over a period of three years in all types of oral surgery has convinced the writer of its efficacy in helping to control post-operative swelling. Another drug currently being used as a specific against post-operative inflammation is C.V.P. with Cortisone (Arlington-Funk). However, this drug is more costly and no statistics have yet been accumulated.

The need for pre-operative and post-operative antibiotics is self-evident. Penicillin V (500,000 i.u. t.i.d.) gives adequately high blood levels to warrant its use as a prophylactic in many cases of mouth surgery. Others of the wider spectrum variety may be used, e.g., Erythromycin 250 mgms q.i.d. and Achromycin 250 mgms q.i.d.

Within about 3 months post-operatively, X-ray evidence of bone regeneration should be clearly seen and, in 6 months to one year, the bony cavity should be filled with new bone.

The same technique may be used for both upper and lower anteriors but it must be remembered that the labial plate of the mandible is considerably thicker than that of the maxilla.

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HMCS BONAVENTURE CRUISE - WINTER 1961

Major J McGaughey, CD, DDS

HMCS Bonaventure left Halifax on 24th January with the members of the Permanent Joint Board on Defence aboard as guests. The following day we encountered extremely rough seas which must have been a real experience for many of the guests. On Friday, 27th January the PJBD members disembarked at Bermuda and proceeded to their various destinations. For the next week we carried out exercises at sea in the Bermuda area under pleasant weather conditions and the following week-end spent four enjoyable days ashore in Bermuda, and then proceeded to Norfolk, Virginia. During the eleven days spent at Norfolk, a two-day symposium was carried out at sea, the Bonaventure again being host to a large number of important people. From Norfolk we returned to Bermuda carrying out exercises in the meantime and on 3rd March left the Bermuda area for San Juan, Puerto Rico and a very pleasant six days. On 12th March we sailed from San Juan and arrived in Halifax on 17th March to discover that we had left beautiful summer weather and returned to the rigors of winter climate.

A great deal could be written about any one of the places visited but discussion will be limited to the points of interest which I personally visited in Bermuda, Norfolk and Puerto Rico, and in that order.

Bermuda, a chain of semi-tropical islands with a population of approximately 38,000 people, is about 24 miles long. The roads are narrow and winding and for the most part paved. The chief means of transportation is by small motor car, bicycle, or motor assisted bicycle. The weather is very pleasant and, based on a 65-year study, the average low temperature is 56.5° F. which occurs in February and the average high temperature is 85.8° F. which occurs in August. There is no rainy season and no month in which the rainfall is excessive or sufficient to interfere with the enjoyment of outdoor recreation for any length of time.

The buildings and private homes of Bermuda have an unusual feature which immediately impresses the visitor. The roofs are designed to funnel all rain water into eave gutters which in turn drain off into tanks which are a fundamental part of the structure. This is most necessary since there is no other source of fresh water.

Hamilton, the capital of Bermuda, is a clean, well-planned city. Some of the interesting places to visit are the Bermuda Cathedral, the Parliament Building and Session House, which is the second oldest parliament in the British Empire, the Bermuda Library and the Historical Museum. There is a wonderful shopping district where perfume which is produced locally, may be purchased at a relatively low price which makes a nice gift for your wife or sweetheart.

For those who like to participate in sports there are many facilities available. There are three fine 18-hole golf courses and two with nine holes. Fishing is very popular and excellent facilities are available for swimming, sailing, underwater sports, water skiing and tennis. Generally speaking, Bermuda is a home for retired wealthy people and for tourists who can afford to spend the winter months there.

Having spent eleven days in Norfolk, this article would not be complete without briefly discussing two places of great interest, Jamestown and Colonial Williamsburg. At Jamestown, in 1607, one hundred and five men and boys arrived from the Old World and laid the foundations of the United States of America. At the Jamestown Festival Park are hung paintings and portraits which dramatize the life and struggles of the first permanent English settlers in America. The three ships which brought the colonists to America are also on display, still well preserved and apparently sea-worthy.

Williamsburg, which is about 20 miles from Jamestown, has a very important historical past. In 1698 the legislators of the new colony in America moved their capital from Jamestown to Williamsburg, which was named in honour of the reigning English monarch, William III. Until 1780, when the capital was moved to Richmond, this town was the political, social and cultural centre of the whole colony. Also during this period Williamsburg was the seat of government for Britain's largest colony in America, and was the headquarters for legislation which overthrew the rule of the Crown. From 1780 until 1926 Williamsburg fell into the background but beginning in 1926 through the generosity of Mr John D. Rockefeller Jr., the city has been restored to its early appearance and is now called Colonial Williamsburg.

Colonial Williamsburg, which is one mile long and one-half mile wide has a population of 8,000 inhabitants. The neat weather-boarded houses of colonial days have been restored in great detail, including their beautiful gardens. In addition, they have re-created a living community in which the inhabitants wear the costumes of their ancestors and work with the tools of colonial days. We were escorted on a guided tour through many places of interest such as the Governor's Palace, the Capitol, the Gaol, Bruton Parish Church, and Raleigh Tavern. The British influence of the period is evident and in many cases the furniture, tapestries, oil lamps and cooking utensils are original.

Having visited Norfolk and Bermuda, let us now proceed 750 miles farther south and visit one of the beautiful islands in the Caribbean, the land of sunshine, fruit and flowers, Puerto Rico.

Puerto Rico (Rich Port) has played a major role in the turbulent history of the West Indies for more than four centuries. Its history reads like fiction rather than fact. The Spanish slave traders, smugglers and buccaneers have all left their imprint upon its present day culture. Discovered by Christopher Columbus in 1493, Puerto Rico is the only island that Columbus actually visited which flies the American flag. In 1509 Ponce de Leon became its first governor and formed the first white settlement. For nearly 400 years the island was a strong outpost of the mighty Spanish Empire, successfully resisting occupation by the British and Dutch. After the Spanish-American War, under the Treaty of Paris, the island was ceded outright to the United States and in 1952 was proclaimed a Commonwealth, making it a self-governing member of the Union.

San Juan, the capital of Puerto Rico, has a population, including the metropolitan area, of about 590,000 people. It is comprised of two sections: old San Juan which is situated on two rocky islets guarding a fine harbour and linked by bridges with the mainland; and new San Juan which is a very modern city in all respects. Old San Juan with its narrow streets and plazas maintains its Spanish character and has many well preserved historic buildings. Some of the most significant buildings and structures

are: the high battlements of El Morro commanding the entrance to San Juan Bay; La Fortaleza, now the Governor's Palace; the old Spanish Cathedral with the tomb of Juan Ponce de Leon; the Federal Building; and part of the University of Puerto Rico.

To appreciate the varied beauties and fascination of this "Island of Enchantment", one has to go beyond the environs of the large luxury hotels in San Juan. In this respect I was fortunate enough to be among a group of five who were provided with a car and chauffeur to drive about the island on a sight-seeing tour. As a point of interest, we selected El Yunque which is a 3500 foot mountain about 40 miles from San Juan. Driving through the country we were much impressed with the large dairy herds and the rich agricultural area which produces mostly sugar-cane. Having reached the top of El Yunque, we marvelled at the giant tree forms and lush vegetation which grew there. This is part of the Caribbean National Forest, where 200 inches of rain falls annually, and is one of the few tropical rain forests in the world.

Tuquillo Beach which can be seen from El Yunque is one of the most beautiful in the Caribbean. The lovely white sand beaches, shaded by tall, stately palm trees inspired most of the ship's company to acquire a Puerto Rican tan. The water temperature was about 80° F. on Friday, 10th March.

For history lovers the old fortresses provide a veritable paradise. Probably the most outstanding are the ancient El Morro and San Cristobal, both of which remain essentially the same as when occupied by the Spanish and are considered to be the best examples of old military architecture in United States territory. On the site of El Morro fortress is Fort Brooke which has one of the world's most unique golf courses. At one hole the golfer must tee off over a thirty foot wall built more than 400 years ago.

A visit to San Juan would not be complete without patronizing some of the elegant night clubs. The bands and floor shows are excellent and the environment magnificent. The El Calypso, with its wonderful steel band and nightly limbo contests, should not be missed. The hospitality and friendliness of the Puerto Ricans is inspiring and we should drink with them their toast "Salud y pesetas ------" - "health, wealth and the time to enjoy them".

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DIRECTORATE OF DENTAL SERVICES NEWS

New Appointment

The Minister of National Defence has granted authority for the appointment "Director General of Dental Services" to be re-designated "Director General of Dental Services for the Canadian Forces". It is generally known in the Services that this appointment carries a tri-service responsibility and the new title should clarify this for other government departments and civilian organizations.

Duty Visits and Trips

Dental facilities in No 12 Coy were inspected by Brig KM Baird in March. On the 10th of April he attended the Workshop Conference on the Role of Auxiliary Personnel in Dentistry held in Toronto.

In early February Col GB Shillington visited the US Navy Dental Corps Headquarters in Washington and proceeded on to Chicago where he attended the meetings of

the American Denture Society. A later trip took him to The RCDC School to interview officers on course and to Toronto as the DGDS representative at a meeting of the Council on Education of the Canadian Dental Association.

The annual inspection for the Militia General Efficiency Competition has just been completed by Col HL Harris.

Lt Col JG Butler, Major Protheroe and Major DH Hillier have represented the DGDS at meetings of the Editorial Board of Oral Health.

Arrangements for the last phase of the RMC Fluoride Study were made on 21 April in Kingston by Major DH Protheroe, the study director.

Postings

We all wish Cpl JG Moore well in his new duties with 11 Coy.

Training

Lt Col JG Butler and Major DH Hillier attended the Physicians' and Dentists' Indoctrination Course at the Civil Defence College in March.

A short course designed to demonstrate the application of public health principles to the RCDC was presented to senior RCDC and US dental officers at Camp Borden by Major DH Protheroe and Major DH Hillier.

Special Events

A mixed mess dinner was held at the AHQ Officers' Mess on 7 April. The guests of honour were the Adjutant-General, Major-General JDB Smith and Mrs Smith.

Lt Col JG Butler was again a member of Lt Col Bill Timmerman's rink which won the local Inter-Service Bonspiel for the third straight year.

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NO 1 DENTAL EQUIPMENT DEPOT

Duty Visits and Trips

In late February WO 1 Church spent a week in Chicago at the Midwest Dental Mfg Co where he received instruction in the repair and maintenance of their equipment. He later visited Ottawa to carry out repairs to equipment.

Promotions

Our congratulations to Sgt Dick Claydon on his promotion to S sgt. A native of Ottawa, Staff Claydon has served continuously since 1941, seeing service in Canada and UK during the Second World War, and in the post-war period he has had tours in Korea and Germany as well as Canada.

Postings

We extend a warm welcome to Cpl McRoberts, a recent transfer from the RCAC and to Mrs Thelma Gendron. At the same time we bid farewell to Mr Allan Anderson who has resigned his position with us.

Special Events

Major Fletcher and WO 1 Church have completed interesting but arduous tours as PMC of their respective messes.

We are in the midst of a physical fitness programme using the 5 BX plan and the results are most encouraging.

Major Fletcher has been elected President of the Petawawa Curling Club for 1961-62.

WO 2 Maxie Fisk had a very good year on the curling ice, skipping rinks to victory in three events and to the semi-finals in the Command Bonspiel in Camp Borden.

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THE RCDC SCHOOL

Promotions, Retirements and Releases

Congratulations to Sgt Bradley on his promotion to S sgt. A native of Pickering, Ont, Staff Bradley enrolled in 1940 and following two years with the infantry transferred to the CDC. He remained with the Corps following the Second World War and following a tour with the "I" Staff in BC Area came to The RCDC School in 1958. Staff Bradley is employed as a DT Cl and resides in Barrie with his wife and two children.

Congratulations also to Cpl Arnold Semple on his recent promotion to Sgt. A native of Toronto, he enrolled in 1951 and has seen service in Korea and CBUME as a storeman. Much to the relief of the CFMS Softball Team, the School Volleyball Team, and the QM, Sgt Semple will continue to serve at the School.

US Dental Officers Attend RCDC School

The first US Dental Officers to attend a Clinical Course at The RCDC School are shown discussing a problem with members of the School staff.

L to R - Lt Col LG Craigie, Lt Col J Lancaster (US Army, Fort Dix, New Jersey), Col BP Kearney, Cdr L Armstrong (US Naval Dental School, Bethesda, Maryland), Lt Col SG Bagnall

Training

Major George MacDougall departed 19th February to attend a 12 weeks' Prosthetic Course at the US Naval Dental School, Bethesda, Maryland.

Vital Statistics

Major Bill Thompson is in Toronto Military Hospital.

Special Events

On 16th March, the second annual curling classic was held between members of the Officers' Clinical Course and the School Staff for the coveted trophy, presented

and won last year by the 1960 Clinical Course skipped by Major Bill Dickie. This year the School rink skipped by Col Kearney with Lt Col Craigie as third and Captains Wright and Van Ryssel on the sweeping end defeated the Clinical Course team composed of Skip Major Frank Charman, Majors Don Schwartz (US Army Dental Corps), Pete Falkner and Capt Frank Lovely (on loan from the School).

The Garth C Evans Trophy, for annual competition between the officers of the CFMS and the RCDC in Camp Borden, was won by the RCDC School with a 14-point advantage for the two games. This is the first time that competition has been held for the trophy donated by our former Chief Instructor.

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11 DENTAL COMPANY

Duty Visits and Trips

Col HL Harris and Capt WJ Bignell were recent visitors to the Coy.

BC Area clinics were inspected by Col Millar in January. During this trip he joined medical and dental officers for a most informative clinic on facial injuries presented by staff members of Shaughnessy Hospital.

Capt Lloyd Wansbrough also completed a tour of the company recently.

Service personnel and dependents at Aklavik and Inuvik were made dentally fit by Capt Lee Reynolds and Sgt Gerry Keogh, and the team of Major Ty Cobb, Sgt Mickey Kidd and Sgt Ralph Thornton completed treatment at Dawson Creek and Fort Nelson. In January Capt Dick Welsh and Cpl Bob Lowery visited RCAF Stn Holberg and another trip to that location was made in April by Capt Jack Bowman and Sgt Bingo Shaw.

Promotions and Retirements

Our congratulations to Alex Ponton and Merv Fediuk on their recent promotions to WO 2 and S sgt respectively.

WO 2 Ponton, a native of Brantford, Ont served from September 1939 in Canada, UK, Italy, and NWE until he took his release in November 1945. Alex re-enrolled in 1949 as a Storeman and in addition to service in Canada had a tour with the Air Division in France. He is married with one child.

Staff Fediuk was born in Watson, Sask in 1935. He enrolled in the RCDC in 1952 and has interspersed his time in 11 Coy with trips to Korea and CBUME. Originally trained as a DA he was remustered to a DT Cl in July 1960. Merv, who is single, is stationed in Cold Lake.

Capt Dick Welsh, Cpl Pete Coupe and Cpl Pete Eastwood have taken their release and Mrs Delia Wickes has also retired. We wish all of them well.

Postings

Since the last issue we have welcomed Sgts RA Malpas and NC Petersen from CBUME, Cpl Gil Moore from DGDS and Pte Walter Webster from PPCLI. Our losses to other units were Sgt John Christiansen to CBUME, Sgt W Olynyk to 13 Coy and Sgt Marc Tremblay to 15 Coy.

Training

The following personnel have completed the courses listed:

Lt Col Crummey and Major Charman - Officers' Casualty Care and Clinical Course at The RCDC School

Major Kettyls - Crown and Bridge at the University of Michigan

Major Walker - Oral Surgery at Ent Air Force Base, Colorado Springs

Sgts Dean, D'Eon, Kidd and Robertson - Dental Assistant Instructors' Course

Sgt Kennedy - Dental Technician Laboratory Instructors' Course

Cpls Wilkinson and Moore - Sr NCO Course

Sgt Franzgrote, Cpl Taylor, Cpl Lowery, Pte Schwarze and Pte Monahan are currently attending courses

Expression of Sympathy

Our sincere sympathy is extended to Major and Mrs Leon Richardson on the recent death of their son, Peter Bruce.

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12 DENTAL COMPANY

Duty

The most important event in the past three months was the inspection of the unit by the DGDS. It is very gratifying to be able to talk out problems and learn a little about future career probabilities. The only group missed were aboard HMCS Bonaventure off the coast and the sea was too wild to board.

Capt Frank Lovely has returned after four weeks' replacement duty at The RCDC School clinic.

Training

The following personnel attended courses:

Lt Col WR Cunningham	RCDC(S) Offrs Clinical & Casualty Care
Lt Col NA Butcher	RCDC(S) Offrs Clinical & Casualty Care
Major Al Taylor	RCDC(S) Offrs Clinical & Casualty Care
Capt Ike Gordon	USNDS Partial Dentures
Sgt Ken Wallace	RCDC(S) DT Lab Instr
Cpl Earl Schell	RCASC(S) Sr NCO
Cpl Roy Matheson	RCASC(S) Sr NCO
Cpl Frank MacKay	RCASC(S) Sr NCO
Cpl Henry Nogler	RCASC(S) Sr NCO

Accommodation

Our QM Stores has been enlarged by the addition of two clinic bays from the Stadacona clinic.

Vital Statistics

Congratulations to the following:

Major and Mrs Tom Gaudet	-	a daughter
Capt and Mrs ES Morrison	-	a daughter
S sgt and Mrs Bob Stewart	-	a daughter
Sgt and Mrs George Ryder	-	a daughter

Our 1960 graduates Captains Syd Campbell and By Johnston are both recuperating from spells in the hospital. Reports indicate that this is a predominant trend throughout the Corps.

Camp Gagetown Clinic Personnel

Front Row - L to R - Capt WF Shaw; Major DE McDermott; S sgt PAA Egan

Back Row - L to R - Pte A Pink, Sgt KL Wallace; Cpl RF Matheson; Cpl FW MacKay

(Four members of the clinic are missing from this photograph)

Special Events

Sgt Doug Murley returned from Bermuda in time to proceed to the Command Hockey Championships at Camp Gagetown; Capt Bill Shaw took part in the Command Basketball Championship in Halifax; Capt Jack Quackenbush and his Stadacona rink bowed out of the Nova Scotia Consols playdown with a 2-2 record. Capt Hal Bunston and his cohorts from Shearwater won the Atlantic Command Volleyball Championship and Capt Mullins has all his fishing gear in good shape for 15th April.

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13 DENTAL COMPANY

Promotions and Retirements

Major George L. Finkbeiner commenced retirement leave on 1 Apr 61 following 18 years' service with the Corps. A native of Milverton, Ont, he attended High School in Listowell, Ontario and received his dental undergraduate training at Marquette University, graduating in 1935. Following a year's graduate studies at the University of Toronto he entered private practice in Listowell. In Oct 40 he joined the Corps and served in Canada, the United Kingdom and Northwest Europe until Oct 45 when he returned to private practice in Listowell. He rejoined the Corps in Apr 48 and has served in 12, 13 and 14 Coys since that time.

Major Finkbeiner, who is married with two children, plans to continue his association with the Corps in a civilian capacity.

Also recently retired from the Corps is Sgt Amerigo Pasquini after 17 years of continuous service. He enlisted in Montreal in May 44 and has served in 11 and 13 Coys as well as a tour in Germany from 1954 to 1956. Sgt Pasquini plans to continue residence in Kingston with his wife and two children.

Our congratulations are offered to three members of this Coy promoted since the last issue of the Quarterly:

S sgt JE Shiner to WO 2 effective 9 Dec 60
Sgt JCA Therrien to S sgt effective 30 Dec 60
Pte NAJ Eady to A/Cpl effective 15 Dec 60

A native of Vancouver, WO 2 John Shiner enlisted as a chair assistant in the CDC in Oct 40. During the war he took part in the Kiska Expedition to the Aleutian Islands and served in Londonderry, Ireland with the Navy until his discharge in 1945. He re-enrolled in the Corps in Nov 47 as a dental assistant, later remustered to DT Lab, and has since qualified and remustered to a DT Cl Gp 4. John, at present stationed in Ottawa, is married with two children.

S sgt Therrien is a New Brunswicker. He enlisted in Jan 51 as a dental assistant and has seen service in Germany and on "I" Staff. In Jun 60 he qualified as a DT Cl and is currently employed at RCAF Station Clinton, where he resides with his wife.

A native of London, Ontario, Cpl Eady is a former Navy Administrative Writer, having served a five-year hitch with the senior service in HMCS Naden and Bonaventure. He enrolled in the RCDC in Jun 58 and has qualified as a DA Gp 2, but is currently employed at Coy HQ in Trenton for training as a Clk Adm. Cpl Eady resides in Trenton with his wife and two daughters.

New arrivals include Sgt AJC Gagnon and Sgt W Olynyk, now stationed at Uplands, as well as, Cpl DB Loosley, a transfer from RCA who reported to Camp Petawawa on 3 Jan and Pte OW Mandrusiak from the PPCLI Depot who is employed at 15 Clinic in Trenton.

Training

The following attended courses during the period Jan - Mar 61:

Col AC Leman	-	Civil Defence, Armprior
Lt Col RHG Cunningham	-	Officers' Clinical and Officers' Casualty Care
Major PL Falkner	-	Officers' Clinical and Officers' Casualty Care
Major PS Sills	-	Dentistry Advanced - Walter Reed Army Medical Center, Washington, DC
Sgt JRAOLP deBlois	-	DT Cl Gp 3
Cpl G Sapergia	-	DT Lab Gp 1
Cpl BH Sims	-	Sr NCO
Cpl RJJ Tremblay	-	Sr NCO
Pte C St C Sabine Pasley	-	DT Lab Gp 1
Pte RH Stenabaugh	-	DT Lab Gp 1
Pte RL Geddes	-	Jr NCO

Vital Statistics

A son, Charles Keith, was born 5 Jan 61 to Capt and Mrs CG Travis.
A son was born to Lt Col and Mrs WA Anglin on 21 Apr 61.

We regret the sudden passing of S sgt Weir's wife, Dorcas, following a car accident near Cobourg on Sunday 22 Jan in which Bill and his two children were seriously injured. The children are expected to be up and around shortly. Bill, however, will be in hospital for some time yet.

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14 DENTAL COMPANY

Promotions, Retirements and Releases

Capt Dave Cook, one of the Corps' originals, has received advice that his retirement will be effected in June. Dave was born in England, coming to Canada as a youngster of three and receiving his education in Victoria, BC. He began his military service with the Militia in 1924, enlisted with the Canadian Scottish in 1939, transferred to the CDC in 1940 and attained the rank of WO 2. He was commissioned in 1956 and at present is Captain QM with 14 Dental Company in Winnipeg. Dave will be SOS to 8 PD for release proceedings on 30 Jun 61. The Cooks have two children and intend to make their retirement home in Victoria, BC.

Retirement also has claimed Sgt Howard Habart who served with the CDC from 1941 to 1946 and re-enrolled in 1951. Howard was born in the province of Quebec, is married with three children and expects to continue to reside in Winnipeg. He will be SOS to 8 PD for release proceedings on 27 Jun 61.

Postings

Capts Doug Bunt and Claude Arpin have been alerted for a tour with the Dental Detachment in the Middle East.

Training

Capts Bob Bryant, Leo Bourget and Herman Cashin are anxiously awaiting the results of the Captain to Major Pre-Course exams which they wrote in March.

Courses attended by 14 Coy personnel recently are:

Major Joe Lauziere	-	Medical and Dental Practitioners Indoctrination Course, Civil Defence College, Arnprior
Capt George Moore	-	Unit Fire Prevention Officers' Course - RCSME, Chilliwack
Sgt Dawson Casson	-	DT Lab Instructor Course at The RCDC School

Lt Col Purdy has been lending assistance to the teaching staff at the Faculty of Dentistry, University of Manitoba in the Department of Prosthodontia, which is headed by Dr Harold Hart, a former respected member of the Corps who retired in 1958.

Visits and Trips

Recent visitors to the unit from Ottawa have been Col HL Harris and Capt John Bignell. The latter visited in January to discuss personnel matters and Col Harris was in Winnipeg to inspect No 57 Dental Unit (M) in early April.

Major Jim Jolly and Cpl Richard Walker of Fort Churchill are now listed among small groups of personnel who have provided treatment at Alert, NWT by virtue of a trip there in March.

Lt Col and Mrs Purdy have returned from a most pleasant mid-winter vacation in Mexico City and Acapulco, where they spent the time sunning, swimming and sightseeing.

Special Events

The Unit Annual Curling Bonspiel was held in March at the RCAF Winnipeg rink. Teams from Camp Shilo, RCAF Station Winnipeg, Fort Osborne Barracks and HQ Staff competed. The defending rink from Camp Shilo skipped by S sgt Ross Taylor won the event. Sgt Keith Laurence is to be congratulated for so successfully organizing the curling, the supper and dance which followed.

Sgt Gord McGunigal's rink dominated the Camp Shilo bonspiel and won most of the honours at this event.

Capt George Moore has been recently appointed Fort Osborne Barracks Officers' Mess Secretary.

A committee, headed by WO 1 Ben Gareau, is making arrangements for a dinner dance at the Fort Garry Hotel, Winnipeg, when presentation of prizes will conclude the unit Bowling League activities for the season.

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15 DENTAL COMPANY

Promotions

Cpl P Dignard's promotion to Sgt was very welcome news. Sgt Dignard enlisted in 1950 and following service in Korea the old Van Doo transferred to the RCDC as a DT Lab. He is now stationed in Quebec City where he resides with his wife and three children.

Pte JAJ Fret's promotion to Cpl was also announced recently. Cpl Fret, who was born in Antwerp, Belgium and came to Canada in 1952, first served as a gunner from 1956 to 1959. He re-enrolled in 1959 in the RCDC as a DA and is now employed at St Jean where he resides with his wife and one child.

Postings

Major Bob Dyer has recently left us for the saltier clinics of the Maritimes.

Major PH Guevremont has once again rejoined the "15 Dent" after a tour aboard the "Bonnie".

Sgt M Tremblay made the long trek from BC and is now firmly entrenched in the new clinic at St Hubert.

Capt Ted Lesage will be leaving us soon and we all wish him good luck on civvy street.

Duty Visits and Inspections

This unit was recently honoured by a visit from Brig KM Baird who officially opened the new dental clinic at RCAF Stn St Hubert. (See photo next page)

The Air Officer Commanding Training Command, AVM HM Carscallen, DFC, CD, visited our QM Stores at St Jean 21 Feb 61. He was very impressed by the wide range of clinics supplied from this outlet and by the stores layout in general.

Col TL Marsh recently made his final inspection of all detachments in this Command prior to his forthcoming retirement.

New Clinic Opened at St Hubert

The new Dental Clinic at RCAF Station St Hubert was officially opened on 6 Mar 61. Brigadier KM Baird, Director General of Dental Services is shown in the centre photograph cutting the ribbon. Looking on (R - L) are Group Captain WB Hodgson, Commanding Officer of RCAF Stn St Hubert, Air Commodore JB Harvey, Chief Staff Officer, Air Defence Command and Major ED Fraser, Senior Dental Officer of the new clinic.

The clinic is situated in the station hospital and, as can be seen in the other photos, is beautifully appointed and equipped.

Training

The following personnel successfully completed courses:

Lt Col AR Smith	-	Officers' Clinical Officers' Casualty Care
Major J Durand	-	Officers' Clinical Officers' Casualty Care
Major JD Bourque	-	Minor Oral Surgery
Major HE McKenna	-	Periodontics
Capt WA Sugars	-	Radiology
Sgt A Bourgeois	-	DT Lab Instrs
Sgt JP Dignard	-	Sr NCO
Cpl AW Hussey	-	Clk Adm Gp 3
Cpl JAJ Fret	-	Jr NCO

Cpls AE Werkmann and G Dancer are still battling with the DT Lab Gp 1 course at the School. Good luck fellows.

L Sgt "Ernie" Jermain, the Kapuskasing Kid, recently passed his Sr NCO pre-course assessment and is huptwo-threeing it at QM Stores anxiously awaiting the next step.

Vital Statistics

LAW Donna McNeill was married to RCAF Cpl DJ Hollins on 9th March at St Jean. Best wishes, Donna, and good luck in Europe.

The engagement of AW1 Babish to LAC Bob Kennedy of RCAF Goose Bay was recently announced. Congratulations!

New arrivals were confined to College Militaire Royal this time. The proud parents are:

Capt and Mrs Luke Bosse	-	a son - Joseph Jacques Marc Andre
Cpl and Mrs Marcel Chayer	-	a daughter - Lise Guylaine Marie

Special Events

Col and Mrs Marsh were patrons of the Annual Formal Ball of the Dental Students of McGill University on 3rd March. They also represented Major-General and Mrs JM Rockingham at the Montreal St Patrick's Society Ball 17 Mar 61.

Curling seemed to be the most popular sport in the Coy this winter, even Capt Lionel Jacob got into the act. Skiing, although not indulged in by everyone, enjoyed a fairly good season, particularly at Command HQ. Capt Harrison again helped out in the capacity of treasurer and assistant secretary of the Montreal Branch of the Canadian Army Ski Club. Members at Goose Bay seem a bit downcast since all ice fishing shacks had to be off the ice by 1st April. They have a summer fisherman's paradise, however, at Muskrat Lake, about 45 minutes from the base. With food, sleeping accommodation, boats and motors for $3.00 per day, plus the fringe benefit of "no women allowed", this is indeed a haven to which work-weary members may retire.

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4 FIELD DENTAL COMPANY

Postings

Capt Bisaillon, Sgts Palmer, Shields and Toole make up the group returning to Canada from 4 Field this summer. Word has been received that they will be employed in 14, 11, 15 and 11 Coys respectively.

We look forward to welcoming as replacements, Capt DJ MacPhee and Sgt McDonald.

Training

WO 2 PL Gourlay, Sgt JR Cahill, Sgt JAR Shields and Cpl CC Millard attended a course on the Organization of Medical Services, 24 Basic Procedures and First Aid held by 1 Field Ambulance in January.

Visits and Trips

Lt Col Evans and Sgt Toole visited Antwerp for 2 weeks in February to examine DND school children and provide treatment for personnel of 1 Cdn Base Ordnance Unit.

Maj Skinner and Cpl Posyluzny have both visited 35 Fd Dent Unit recently.

Vital Statistics

Congratulations to Sgt and Mrs JE Clarke on the birth of a son at BMH Iserlohn on 10th March.

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35 FIELD DENTAL UNIT

Promotions, Retirements and Releases

Congratulations are being offered to Capts Lew Kelland and Art Hinch on their promotions to Major, effective 1 Apr 61 and 16 May 61 respectively.

Major Kelland, a Nova Scotian, attended St Francis Xavier University in New Brunswick and Dalhousie University, receiving a BA, BEd and DDS. Following graduation in 1954 he was posted to 12 Coy and in 1958 was transferred to France. Major Kelland is married with two children. Capt Hinch, a Haligonian, attended Dalhousie University, graduating in 1947. After enrolling in 1956 Capt Hinch served in 12 Coy until he was posted to France. He is married with one child.

Cpl Shirley Morken has returned to Canada to take her release from the RCAF.

Postings

Personnel of the unit returning to Canada this summer on completion of their tours include Lt Col Ross Covey, Majors George Windsor, Ian MacDonald, Lew Kelland and Sgt Gar Grundy.

Training

Sgt Helmut Marckwort returned to Grostenquin in February following attendance on the Senior NCO Course at Camp Borden.

The ROYAL CANADIAN DENTAL CORPS Quarterly

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THE RCDC QUARTERLY

Published by authority of Brigadier KM Baird, Director General of Dental Services for the Canadian Forces

Editorial Board: Col GB Shillington
Maj DH Protheroe

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Cover Photo - Aerial View of Fort Churchill

E D I T O R I A L

Clinic Returns

The compilation of dental treatment and laboratory returns is a responsibility which must be accepted by all dental clinic personnel, although, from time to time doubts are expressed regarding the need for and desirability of these records. In view of this, it is perhaps appropriate to review the need for clinic returns.

First of all, it cannot be denied that the primary role of the RCDC is to provide dental treatment and consequently, the amount and type of dentistry performed is probably the most important measure of the Corps' progress. In this regard, the records show that over the past ten years there has been a 20.5% increase in the amount of dental treatment provided per duty day. All personnel should take pride in this accomplishment.

Secondly, and equally important, the data compiled from clinic returns are fundamental to planning and to the direction of the Corps. They have formed the basis for submissions which have obtained, and continue to obtain, such improvements for the Corps as laboratory officers, the new subsidization plan, research activities and Dental Officer Allowance; they are used to estimate financial requirements and stores purchases; they can also influence training policy and the employment of auxiliary personnel, in addition to being the source which permits accurate replies to enquiries from higher authority.

It is readily apparent, then, that the information obtained from clinic returns is essential for effective administration of the Corps. However, the accuracy of this information is dependent upon the integrity of clinic personnel and their ability to complete returns in accordance with the Manual of Dental Services.

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1960/61 Statistics

During the 1960/61 fiscal year 528,676 dental operations, worth $2,606,301, were performed by Corps personnel in 35,115 working days on 354,522 patients. Included in these operations were 139,976 amalgams, 35,029 silicates, 1000 bridges, 4,022 complete dentures, 4,559 partial dentures, 15,619 periodontal treatments and 872 root canals.

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NO 14 DENTAL COMPANY

Col CE Purdy, CD, DDS

No 14 Dental Coy came into being on the 28th of June 1950. Prior to this date, the vast areas of Western Canada from the Ontario border to the Pacific Ocean were served by 11 Dental Coy with Headquarters in Alberta. Lt Col JA MacGowan was appointed to command 14 Coy and arrived at Fort Osborne Barracks, Winnipeg, to assume his duties on 5 Jul 50. The initial strength of this unit comprised 5 dental officers and 12 other ranks. The establishment of a Headquarters, Stores element and additional clinics soon swelled the unit's strength and in Nov 50, the unit paraded for inspection by the General Officer Commanding, Prairie Command.

The Area of responsibility of 14 Dental Coy includes the provinces of Manitoba and Saskatchewan which comprise half a million square miles of variable terrain. Although many Canadians picture the area as a vast treeless plain, a closer inspection reveals that the provinces are two-thirds wooded and covered with numerous lakes and streams. The southern half of the provinces as seen by the trans-continental traveller are moisture deficient areas which inhibit forest growth. The residue moisture from snow and infrequent rains usually provide a suitable environment for agriculture which gives Canada a prominent place as one of the world's great grain producers. Extremes of temperature are experienced in both provinces during the year. Many beautiful forest and lake areas have been set aside for the enjoyment of the sportsman and holidayer. Beautiful national and provincial parks capture the fancy of nature lovers and provide unlimited facilities for accommodation, camping and water sports of all kinds.

The Headquarters of 14 Dental Coy, located at Winnipeg, administers and supplies the requirements for ten separate clinics located at various service installations across the two provinces. The dental clinic at the far northern establishment of Fort Churchill is somewhat unique with its diversified clientele. At this remote outpost dental service is provided for Eskimoes, Indians, Mariners, civilians, government employees and dependents as well as servicemen of the Canadian and US Armed Forces. The nearest civilian dental facilities are located nearly 500 miles distant. Periodically a dental team from this outpost proceeds north to within a few hundred miles of the North Pole to provide dental services for Canadian Forces personnel at Alert. RCDC personnel on posting to Fort Churchill are eligible to undergo an Arctic Indoctrination Course which involves outdoor living and navigation across the tundra wastelands under severe weather conditions.

Although the treatment load is heavy at all locations, the service population in the Winnipeg area demands the largest clinical facilities. A clinic with 7 operating bays provides treatment services for personnel at Air Training Command Headquarters and RCAF Station Winnipeg. The clinic located at Fort Osborne Barracks is soon to be expanded to provide 5 operating bays. A multiple clinic is also provided at Camp Shilo as well as Fort Churchill. The service personnel at RCAF Stations Gimli, Portage la Prairie, Moose Jaw, Saskatoon and the Canadian Joint Air Training Centre at Rivers are served by full-time single detachment staffs. Clinical services for Headquarters Saskatchewan Area in Regina are provided on a part-time basis and supplemented by the services of the local civilian dental practitioners.

Over the years 14 Dental Coy has been proud of its steady progress and accomplishment in the provision of dental treatment services. Excellent relations with various service and professional groups have been maintained. The cooperation and loyalty of all members of the unit have contributed much for the betterment of all.

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THE MANIPULATION OF RUBBER BASE IMPRESSION MATERIAL

Major SW Muller, CD, DDS

Indirect techniques in Crown and Bridge work have undergone and continue to undergo improvement. To a large extent these changes are due to new impression materials and new methods of producing accurate models. Regardless of how complete the diagnosis or how exacting the preparations, unless this accuracy can be carried through to the working model the result will be something short of perfect.

A wide range of impression materials with variable physical properties are available to the dentist. Plaster, wax and compounds have obvious disadvantages which preclude their use in the intricate, indirect techniques. The irreversible hydrocolloids (alginates) are used with varying degrees of success. Generally these lack the toughness required for an accurate reproduction of fine grooves and pin preparations. The reversible hydrocolloids have been used for many years and are still considered an acceptable material. Their chief disadvantage is the amount of time required for the preparation of equipment. Also, they cannot be electroplated with metal. The silicones have a very limited shelf-life and some difficulties are encountered in acquiring a routinely uniform mix with the use of such a concentrated catalyst. These sometimes produce faulty models with soft chalky surfaces.

The rubber base materials referred to as Thiokols, or more correctly the Mercaptans have gained favour as an impression material in restorative work. Since their introduction a few years ago, several modifications have greatly enhanced their acceptance by the profession. The Thiokols are accurate, elastic, and comparatively stable materials that give a good registration of surface detail. They may be poured in stone or electroformed with silver. In average cases where severe external undercuts are absent, two accurate stone dies can be poured from one impression. Schnell and Phillips [1] report that "successive dies may be poured in one impression with no greater distortion than storage of the unpoured impression for a comparable period".

The rubber base products are marketed in the form of a paste-like base material and a paste or fluid catalyst or activator. When the recommended proportions are mixed together an impression paste is obtained which polymerizes in a short time to a solid rubber. The introduction of light-bodied products has made the use of the syringe possible. The syringe provides an efficient means of quickly and accurately introducing the impression material into prepared cavities. It is particularly valuable in the elimination of voids in critical areas.

Packing

The use of gingival packing is recommended prior to impression taking. The string type, such as "Gingi-pak" is effective in a matter of minutes. A suitable length can be determined from the study model. A single strand is firmly placed deep in the gingival sulcus. This is followed by two more strands twisted together and placed on top of the first. These three strands now form a wedge-shaped mass that will, on removal, allow for the introduction of an adequate bulk of impression material to give a suitable registration of this area. This retraction material should remain in place from five to eight minutes prior to impression taking. When allowed to remain place for such a short period of time no damage to the tissue is apparent.

Drying

Mouth preparation for the introduction of rubber-base materials requires isolation of the area with cotton rolls, placing of a saliva ejector and careful

drying of the teeth and soft tissue with cotton. The teeth should not be air dried prior to taking rubber impressions. The slight moisture remaining after drying with cotton prevents the impression sticking to rough areas on the enamel surface.

Tray Selection

Unless the bridge to be constructed is very large, the small, one quadrant type tray is preferred. One fabricated from perforated metal with a suitable handle may be used in lieu of the stock metal tray. Where the edentulous area comprises two or more missing teeth, the use of a custom made acrylic tray is favoured. This may be readily constructed on the study model. All impression materials are subject to dimensional change after removal from the mouth. This change is more pronounced in areas of greater bulk. The importance of a uniform thickness of impression material is therefore obvious and requires a custom made tray to overcome the bulk of material in large edentulous areas.

The acrylic tray can be made quite easily by placing a thickness of base plate wax over the area to be covered by the tray. Stops are provided by cutting away a small portion of the wax from at least two places on the occlusal or incisal of teeth. The tray should extend at least one full tooth beyond the abutment teeth. With the wax in place on the model, quick curing acrylic is mixed, and when the doughy stage is reached it is pressed over the wax to cover the required area. A strong metal or acrylic handle is then applied to the tray. This should be so placed that it will permit a firm grasp when seated in the mouth. The tray should be removed from the model as the acrylic enters the exothermic stage referred to by Jelenko (2). The removal of the wax provides a uniform space for the impression material. The edges of the tray are trimmed and it is returned to the model for checking. It is advisable at this stage to mark with pencil on the labial of the tray the exact tooth that a particular part of the tray will engage. This greatly simplifies proper seating of the tray when loaded with the rubber material.

Most manufacturers supply an adhesive with their rubber base materials. This should be used on all non-perforated trays according to the manufacturer's directions. It is usually applied to the inside of the tray at least 10 minutes prior to filling. The use of certain adhesives on compound-lined trays is not recommended. Tests should be made beforehand since some act as solvents and result in a softening of the compound and no adhesion.

Mixing

A timing device should be used when mixing the impression material. A total of 10 minutes is usually required from the time of starting the mix until the impression is removed from the mouth.

Rubber base impression materials may be mixed on glass slabs but mixing pads are preferred to eliminate cleaning after use. A large pad is essential for ease of manipulation. The proportions of base and catalyst as recommended by the manufacturer are placed on the pad ready for mixing. If more working time is required slightly less of the catalyst may be used. The blade of the spatula should be coated with the catalyst before starting the mix. Incorporate the catalyst into the base material with a rotary motion until the color is uniform and free of streaks. This method will ensure that none of the base adheres to the blade to remain unmixed. After mixing, the spatula is skimmed over the mass to spread it over a wide area. Small bubbles will appear at the surface and break. The spatula is now pulled across the pad in a manner so that the material piles up on the blade. The tray should be loaded in one operation to reduce the possibility of trapping air.

The Syringe Technique

The introduction of light, regular and heavy bodied materials have allowed for some variation in technique with the use of the syringe. These materials are chemically identical but vary in colour and consistency. The aspirating type of syringe permits easy filling by removing the nozzle and filling the syringe directly from the pad or a dappen dish.

Suggested Procedure

All required materials and equipment should be in readiness before starting the mix. Two mixing pads and two spatulas will be required for the double mix technique.

1. Apply sufficient quantities of the syringe material and tray material to the mixing pads.

2. Set the timer for 10 minutes and mix the syringe material.

3. After one minute the assistant mixes the tray material while the dentist loads the syringe.

4. Remove the gingival packing, dry the teeth and tissues with cotton and introduce the syringe material.

5. The tray, loaded by the assistant, is now placed over the teeth and seated until the stops go to place.

6. Hold the tray firmly in place for at least 5 minutes, then remove from the mouth and wash the impression.

The most inaccessible and deepest parts of the preparations should be filled first. The tip of the syringe should touch the floor of the cavity. The material is built up from the gingival toward the occlusal making certain that all detail is covered. When proceeding mesial to the next abutment tooth, the syringe is not lifted but run across the crest of the edentulous ridge to the gingival border of the next preparation.

Precautions

When all prepared areas are covered, the tip of the syringe should be carried forward over an unprepared tooth before lifting off. In this way the material is not pulled away from a prepared area that might result in a void.

The material in the mouth must be unset and tacky when contacted by the material in the tray to ensure proper union. Minimum time should be lost between injection from the syringe and the seating of the tray.

Single Mix Technique

Excellent results are obtainable by using the single mix technique with either the regular or light-bodied material. An adequate quantity of the material is mixed and after loading the syringe, the remainder is applied to the tray. When the regular material is used with the syringe it is recommended that both tubes of material be cooled in water for ten minutes before using in order to retard the setting time.

Pouring

The impression should be rinsed in lukewarm water after removal from the mouth. It may be coated lightly with a surface-active agent (Debubblizer) and then dried with air before pouring with one of the hard stones. It is advisable to pour the cast as soon as possible after taking the impression. Brass [3] states that "For the enthusiast who likes to do his work on electro-plated dies, the results are even more encouraging, for the Thiokols return a silver plated die of extreme accuracy and detail and are a real thrill to work upon".

Summary

1. The Thiokols are accurate, elastic and comparatively stable impression materials.

2. They can be poured in die stone or electro-plated with silver.

3. The syringe technique greatly reduces the chance of creating voids.

4. A well organized procedure greatly facilitates the handling of these materials.

5. Custom made acrylic trays provide for a uniform thickness of impression material.

6. Hard and soft tissues should be cotton-dried prior to impression taking.

7. The model should be poured as soon as possible after removal of the impression from the mouth.

References

1. Schnell, R.J. and Phillips, R.W. Dimensional stability of rubber base materials. Am.Dent. A.J., 57:48, July, 1958.

2. Jelenko, J.F. and Co. Crown and bridge construction. 3rd ed. 1957. p 78.

3. Brass, G.A. Thiokol - A rubber base impression material. Canad.Dent. A.J. 25:746, Dec. 1959.

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No 1 Dent Eqpt Dep Operations - 1960/61 Fiscal Year

Individual items issued	-	1,671,437
Incoming and outgoing shipments	-	1,358
Number of pieces in shipments	-	10,010
Weight of shipments handled	-	359,893 lbs.

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The Military Training Programme for RCDC Officer Cadets

Lt Col DH Hillier, CD, DDS, MPH and Major JC Brick, DDS

The new Dental Officers Subsidization Plan was announced in the April issue of the Quarterly and the terms of service and benefits were outlined. However, the military training programme was not included in that article. This resume of the undergraduate course of military study, prescribed for dental officer cadets, has been prepared in order that students who are considering enrolment might understand all aspects of the new plan. In addition, it is felt that serving officers should be aware of the scope of the training which the new graduates have received and this information has not been readily available elsewhere.

A recent advertisement in the Canadian Dental Journal, which was directed toward dental undergraduates was entitled "The Best of Two Worlds as an Officer in the Royal Canadian Dental Corps". To achieve the best of each world, as an officer and as a dentist, the best training possible for each profession is a prerequisite. Dental curriculi are designed to provide the training necessary to obtain the greatest good from the dental world. Likewise, the military training undertaken during the Dental Officers Subsidization Plan, is designed to prepare the student for a successful career as an officer in the RCDC.

The training programme is divided into three phases,each of which contains a theoretical portion taken during the academic year, and a practical portion taken during the summer. The aim is to produce an officer basically well-trained, and capable of taking his place in an RCDC clinic. The fulfilment of this aim requires training which provides a broad appreciation of the role of junior officers in general, and a detailed knowledge of those functions peculiar to the RCDC.

The first theoretical phase training is conducted with the university contingent of the COTC and covers 64 periods of instruction which, as in all theoretical phases, are scheduled to interfere as little as possible with the university course. This phase serves as an introduction to the army and covers such basic features as ranks and badges, dress regulations and care of the uniform, customs of the service, pay and allowances, honours and awards and the function of the officers' mess. Certain other fundamental training is carried out, including basic drill movements and a description of the more common weapons and vehicles used in the army. A series of twenty lectures serves as an introduction to the army and to the organization, administration and characteristics of its components. The remainder of the winter's instruction deals with the qualities of leadership, the responsibilities of an officer and military law.

The candidate spends 10 weeks during the summer on First Practical Phase Training at The Royal Canadian School of Infantry (RCS of I) at Camp Borden, Ontario. Here he learns to apply and expand the principles presented during the theoretical phase and he commences the training required to become a junior officer. Although the RCDC is tri-service in employment, it is a component of the Canadian Army and therefore the RCS of I is the logical site for the basic training of dental officers. The course provides an insight into the life and role of the private soldier, the NCO and the junior officer. The cadet becomes familiar with the army life both in barracks and in the field. Through exposure to the basic elements of tactics, fieldcraft, field engineering, leadership and man-management he gains experience at all levels, from a soldier in an infantry section to a platoon commander. Included in this phase of training are lectures and exercises in first aid, map using, military law, staff duties, military writing, security, signal communications and defensive measures used in nuclear, bacterial and chemical warfare. There are 40 periods of physical training and sports to provide mental relaxation and to foster gamemanship in the young adult.

The Second Theoretical Phase which begins on return to university in the fall, is largely a review of material presented during the two previous sessions and serves to consolidate the basic military knowledge which a young officer must have. This phase completes the training known as Common to all Corps and if the cadet has applied himself he will have gained some understanding of military life. These fundamentals are common to all three services.

With this background the cadet is ready for training which is more specific to his role in the RCDC. During the next summer session, which is the Second Practical Phase, the facilities of the RCN and RCAF are used in teaching the organization, administration, customs and traditions of these services. In this way the dental officer learns what will be expected of him and how best to conduct himself when, later in his career, he is posted to a ship or station.

The RCN indoctrination takes place at the Leadership School at HMCS Cornwallis, Nova Scotia, and at HMCS Stadacona, Halifax. The time at HMCS Stadacona is devoted to practical training and, when possible, is carried out at sea.

The RCAF programme is conducted by the Central Officers' School, RCAF Station, Centralia, Ontario. A tour of RCAF Station Clinton is made during the last week of this phase.

The remaining five weeks of second phase training are taken at The RCDC School at Camp Borden. Here, during his first contact with the RCDC, the cadet is taught the organization of the Corps, dental documentation and treatment policy and the role of the dental officer in survival operations. The candidate learns clinical procedures, receives instruction in the manipulation of materials, and in the care and maintenance of instruments and equipment. This concludes the second phase and on return to university the final phase of training begins.

The Third Theoretical Phase is, as in the previous years, carried out in 64 periods. The duties of officers are covered, there are lectures on tactics with sand table exercises; and, an introduction to military history is presented, with recommended reading assignments on the careers of some of the more famous commanders.

At the close of the third dental year the officer cadet goes to The RCDC School for his final training. The aim of this phase is to raise the level of the candidate's knowledge of the Corps in general, and of the clinic routine in particular, to such a level that on graduation the new dental officer will be able to undertake his duties with a feeling of self-reliance.

The time is divided into a formal course of four weeks, and clinical duties of six weeks. The course portion reviews some of the subjects taught in the second phase such as organization and administration, dental stores, documentation and treatment policy and clinical procedures. In addition to this being a review, emphasis is placed on the practical detail of these subjects bearing in mind that the cadet will spend six weeks at clinical duties. He will have the opportunity of exercising his knowledge in treatment planning and documentation. Patients will be assigned to each cadet who will devise and carry out his own treatment plan under the supervision of the clinic instructors. Manipulation of materials, care and use of equipment, methods of sterilization, and all these subjects are no longer words and lectures, but become a part of the normal clinical routine.

In addition to the dental subjects is the ever present national survival training. The officer cadet is taught procedures for the provision of sustaining care for the seriously injured that will utilize the officer cadet's undergraduate training to the fullest extent possible. The procedures chosen are either closely

allied to, or direct extensions of, the medical, dental and para-dental subjects studied. In all, nine procedures are taught which concern: treatment of shock, control of haemorrhage, establishment of an airway, wounds of the abdomen and chest, fractures, burns, parenteral therapy and artificial respiration.

This completes the military programme for the RCDC officer cadet as there is no further training when he returns to university. On graduation and receipt of his licence to practise, the officer cadet is promoted to captain, posted to a dental company and assigned to duty in a clinic.

During his service as a cadet, the young officer has received a thorough indoctrination in the three services and in military dental subjects. He can look forward to many rewarding experiences as a dental officer with the Canadian Forces. The benefits he derives from the two professional worlds in which he finds himself will depend largely on the effort and enthusiasm that he has expended in preparing himself for each profession.

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MOUNTING CASTS WITHOUT A FACE-BOW ON THE HANAU ARTICULATOR

Sgt BPH Buchholz

A letter to the Editor which appeared in the December 1960 issue of the CDA Journal was the inspiration for this article. In his letter, the author emphasizes the importance of transferring jaw relation records by means of the face-bow and points out how infrequently dentists follow this procedure. It is understood that Dental Schools stress the importance of accurate jaw relation records with the face-bow and the Hanau articulator, the instruments of choice. Every technician in the RCDC is trained in the use of these instruments, but occasions do arise when it is necessary to work without them.

The dental technician laboratory is the right hand of the dental officer and the processing partner in the team serving the patient prosthetically. In many clinics this partnership is close; in others it is separated and only linked by "Mail Order". It is not always possible to get a proper and undistorted face-bow registration into the distant lab.

A modified Gysi method is used here to mount casts on a Hanau articulator. To do this, it is necessary to make a slight modification to the Hanau instrument to hold the occlusal plane plate in the correct position on the articulator. On the same level as the crossbar of the "H" on the vertical posts of the articulator, occlusal plane shelves are provided by creating shallow slots. A similar slot may be created on the incisal guide pin but the writer prefers attaching a support to the occlusal plane plate so that free movement is given to the upper member of the articulator as depicted at photo 1. This vertical pin is held in position by drilling a small hole to receive it. The Bonwill triangle * is engraved on the occlusal plane plate and bisected by a line running from the apex to the centre of the base. This line is used for centering the upper cast.

* Editor's Note: The Bonwill triangle is defined as an equilateral triangle bounded by lines from the contact points of the lower central incisors, or the medial line of the residual ridge of the mandible, to the condyle on either side and from one condyle to the other. It is, therefore, assumed that the sides of the triangle engraved on the occlusal plane plate are equal to the distance between the condylar elements of the Hanau articulator. It is also assumed that occlusal plane plate is positioned so that it is parallel to the base of the articulator.

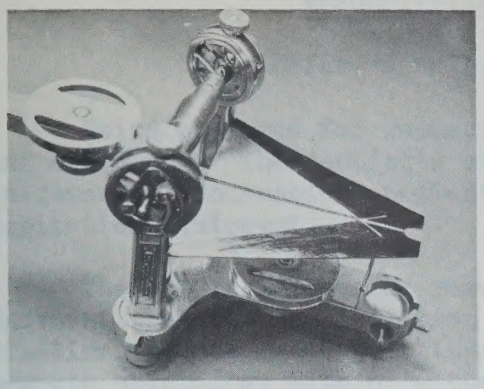

Photo 1

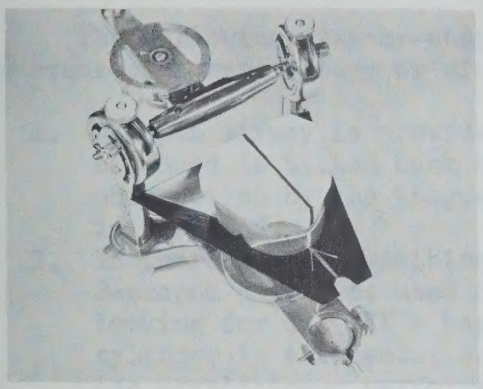

Photo 2

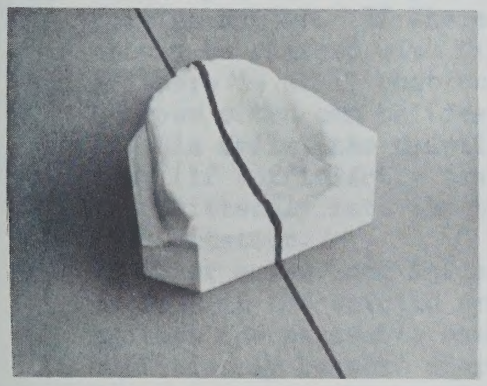

Photo 3

To mount the upper cast:

a. Extend a line upward on the cast from the median line marked on the front of the occlusal bite rim and extend it posteriorly on the flat base of the cast.

b. Draw a line through the middle of the vault along the median Palatine Suture of the upper cast and continue to the base of the cast posteriorly to indicate the posterior extension of the Palatine Suture line on the base of the cast, (photo 3).

c. Place the cast on the occlusal plane plate with the median line of the occlusal rim at the apex of the Bonwill triangle and the line on top of the cast centered along the bisecting line of the triangle, (photo 2).

d. Seal the bite rim to the occlusal plane plate.

e. Mount to the upper member of articulator.

f. When the plaster is hard, remove the occlusal plane plate and articulate the lower cast. Mount the lower cast in the normal way.

A prerequisite for this method is clearly marked, well shaped bite rims with the occlusal plane accurately established in the mouth. Although a face-bow registration by the dental officer is the method of choice for mounting casts on the Hanau articulator, good results have been achieved using the technique described.

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EXODONTISTS PLEASE NOTE!

Abulcasis (1050-1122) was the most important early Arabian author in relation to dentistry. His rules for the extraction of a tooth are very interesting:

1. First ascertain which is the aching tooth.
2. Detach the gum from the tooth with a scalpel.
3. With the fingers or with a light pair of forceps shake the tooth very gently until it is loosened.
4. Keeping the head of the patient firmly between the knees, apply a stronger pair of forceps and extract the tooth in a straight direction, so as not to pull it.
5. If as often happens, haemorrhage is produced, apply powered blue vitriol inside the wound; and if this remedy be ineffective, cauterize the part with a red-hot iron.

Hine, M.K. ed. Review of dentistry. 3rd ed. St Louis, Mosby, 1961, 576 p. (p.503)

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RESUSCITATION IN THE DENTAL OFFICE

Peter Safar. J.Am.D.Soc.Anesthes. 7:5:4-8 May 1960

Being prepared for resuscitation in the dental office requires a minimum of equipment and drugs. The dentist's skill and judgment and his practical experience in the management of unconscious patients are more important than elaborate and expensive resuscitation equipment.

The key to successful resuscitation is immediate oxygenation. Speed is more important than the concentration of oxygen in the resuscitative gas. A few effective inflations of the lungs sometimes are sufficient to restore failing circulation. Mouth-to-mouth breathing, with or without the use of adjuncts, should be learned by all dentists and physicians.

The following step-by-step outline will prepare the dentist for rapid action in the event of a respiratory or circulatory emergency:

1. An open airway is provided. The patient is placed in the supine position, his head is tilted back and his mandible is held forward to prevent pharyngeal obstruction by the tongue. If necessary, an artificial oropharyngeal airway is inserted.
2. If there are no breathing movements, mouth-to-mouth breathing is begun. The S-shaped airway is used if it is available, but time should not be wasted in looking for it. If a bag-mask unit with an anesthesia machine or an oxygen cylinder is available, another person should be asked to get it ready while the practitioner performs mouth-to-mouth breathing.
3. If the patient's lungs cannot be inflated, the pharynx should be checked for foreign matter. If there is solid foreign matter in the pharynx, the pharynx should be cleared with fingers or a cloth.
4. If there is still obstruction, probably it is caused by laryngospasm. Laryngospasm often can be treated successfully by an increase of inflation pressure. If this fails, the practitioner can perform orotracheal intubation or tracheotomy (if sufficiently trained to do so). Then the lungs are inflated by blowing intermittently into the tube. Blind nasotracheal intubation is not suitable for resuscitation.
5. If after a few lung inflations the patient still is apneic and a pulse cannot be felt in the carotid artery, the sternum is pressed forcefully and repeatedly against the patient's back, between lung inflations. This may squeeze the heart sufficiently between sternum and vertebral column to move blood. If the accident occurs in the hospital and there is a competent assistant, "open chest cardiac massage" (left anterior thoracotomy with manual systole) is indicated, but this should not be attempted in the dental office unless the operator is surgically trained and equipment for hemostasis and closure of the chest is available.
6. If the patient is breathing adequately, but his blood pressure is low or unobtainable, a vasopresser drug is injected intravenously, and the patient is placed in a supine position with the head lowered.
7. In the event of convulsions, adequate pulmonary ventilation is provided first, then a small dose of a short-acting barbiturate is injected intravenously.

Editor's Note: Reprinted from the Dec 60 issue of Dental Abstracts by kind permission of the editor, Dr. Lon W. Morrey.

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DENTAL STORES

During 1949 it was found that 142 amalgams were placed for each 5 oz bottle of alloy issued; 0.8 operations, which normally require a local anesthetic, were performed for each carpule issued; and 1.3 X-ray films were issued for each radiograph reported.

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FORT CHURCHILL

Major JW Jolly, DDS

Fort Churchill, Manitoba is located on the sunny, rocky shore of Hudson Bay, slightly north of the 58th parallel, in Canada's sub-arctic regions. It is approximately six hundred miles north of Winnipeg, near the mouth of the Churchill River. The town of Churchill, the only other inhabited area within one hundred miles of the fort, is about four miles away by road.

The first Fort Churchill was built in 1689 and destroyed by fire soon afterwards. In 1731 Fort Prince of Wales was built at the mouth of the Churchill River, where it still stands as an historic landmark. Fort Prince of Wales can be visited by personnel in Churchill by boat in summer, by snowmobile or dog team in winter. The Hudson's Bay Company has had a trading post at Churchill for over three hundred years. The present Fort Churchill was established in 1942 as part of an air route to the UK and was taken over by the Canadian Army in 1946 as a joint services cold weather experimental and training base.

Churchill is Manitoba's seaport from which prairie grain is shipped to Europe during the shipping season from August to October. It is also a main supply point for the eastern Arctic regions.

At present Fort Churchill is staffed by elements of the RCN, CA(R), RCAF, US Army, USAF, Defence Research Board and Department of Transport. Command and administrative control is held by the Canadian Army. All of these services are stationed here to carry out cold weather experimentation and research on various types of equipment and/or training of troops in Arctic warfare.

During the International Geophysical Year, Fort Churchill was chosen as a location for experimental rocket launchings to gather atmospheric and radiation data. This work has been carried on by joint teams of US and Canadian forces and the Defence Research Northern Laboratories until very recently, when a disastrous fire demolished a large portion of the launching area and many valuable instruments. The research teams expect to be back in business in the near future with new and better equipment at their rebuilt site about twelve miles away from the main camp.

It is well known that the weather at Fort Churchill bears little resemblance to that of Florida. The cold and windy climate makes it ideal for testing men and equipment for Arctic employment. Last winter the lowest temperature was forty degrees below zero and the highest windchill (a figure combining wind velocity, temperature, humidity and a few other variables) was 2300. This sounds very unpleasant, but one rapidly becomes accustomed to the cold and learns to dress for protection. In early February, the temperature rose to four above zero and everyone complained of the unseasonable hot spell.

The camp, as can be seen in the cover photo, is situated on a rocky bluff, one hundred feet above sea level and several miles north of the tree line. It is laid out in a compact manner and many of the buildings are connected by heated corridors. It is seldom necessary to go more than three hundred feet in the open air when the weather is really bad. The photo shows in the foreground the RCAF hangar and most of the PMQs; in the middle distance the single quarters, the administrative and working areas and on the right the rocky shore and the frozen bay; in the background top left is HMCS Churchill and the rest is frozen river and tundra.

The camp is well supplied with most of the amenities of life. The two notable exceptions are a swimming pool and a large gymnasium. The DND School has a

small gym but this cannot be used for sports during school hours. Facilities are available for most popular sports and are put to good use. The Garrison Theatre has a new show every night. There are various hobby clubs; a woodworking shop; the craft shop for leather work, painting, photography and ham radio. The local radio station, CHFC, provides news, weather, recorded programs and coverage of major sporting events. The messes, clubs and canteens have very busy schedules and the social life is far more active than on normal stations despite the weather.

Service personnel are provided with environmental clothing for protection from the weather. They consist of parka, wind pants, shearling-lined snow boots and double mitts. The parka is a necessity, the rest need only be worn if one is outside longer than fifteen minutes or if the wind is extremely high. One other occasion for wearing this clothing is during Arctic indoctrination training.

The camp runs a one-week course in Arctic survival for staff personnel who are medically fit and volunteer to attend. The course consists of three days of lectures, demonstrations and films on navigation, use of Arctic equipment, snow-shoeing, building various types of shelters (snow caves, igloos and lean-tos), and other subjects related to Arctic survival, followed by two days of practical application of this knowledge out on the tundra. Everyone takes a turn at navigating, pulling a loaded toboggan, building shelters, cooking, chopping wood for fires and ice for water, cutting snow blocks for building and various other healthy, strenuous jobs in the below zero open air. It's a rugged course but well worthwhile. Four of our clinic staff have participated this winter and all survived despite the odd bit of frostbite, lack of sleep and far more strenuous exercise than normal.

Now from the tundra we turn to "civilization" in the form of the town of Churchill which has about 1800 inhabitants, including the Eskimoes and Indians who live in two camps under the guidance of the Federal government. Churchill boasts two hotels, a liquor store, Hudson Bay store, a semi-supermarket, several stores selling hardware, housewares, furniture and clothing, a bakery, the railroad station, the grain elevator, Canadian Legion Hall and little else of great consequence. The most interesting place in town is the Eskimo museum, which has been set up largely by a lay brother of the RC mission. This museum contains many interesting Eskimo carvings, implements, articles of clothing and hundreds of other objects showing the culture of the Eskimo. At times it is possible to see dog teams driving along the town streets, Eskimoes in colourful native garb and trappers in from their trap-lines. A local character, "Trapper Joe", lives with his dogs, about fifteen miles south of Churchill beside the railway line. Joe has lived in this area for more than forty of his eighty-one years. He is a huge man and looks far younger than he actually is; he loves to have people visit at his cabin and will talk at length about life in the Arctic to any who are interested.

Now a few lines about the clinic. Unlike most other clinics dependents as well as service personnel are eligible for treatment. Also, since the nearest civilian dentist is five hundred miles southwest at The Pas, all the civilians, Eskimoes and Indians from northern Manitoba and the Northwest Territories are potential patients. This occasions an opportunity for the dental officers to enjoy a very diversified general practice. All the detail concerning treatment records, separate monthly returns for various classes of patients, collection of fees from other government departments, that are shown in the Manual of Dental Services are routine at Fort Churchill. Whereas the monthly returns at many clinics consist of several sheets of paper, here they weigh several pounds. Not only is the dental practice diversified but this posting also affords excellent training in administration.

In conclusion, a posting to Fort Churchill is just what the individual makes it. The work is interesting and diversified, the life is different but enjoyable and while the weather is wild it is not really unpleasant. All things considered, Fort Churchill is quite a good posting.

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THE ADAPTATION OF THE HYDROCOLLOID SYRINGE FOR RUBBER BASE IMPRESSION MATERIALS

Capt OA Tucker, DDS

With the advent of new and easier-handling impression materials, the hydrocolloids have fallen into disuse, but the cartridge syringe that is on issue for use with hydrocolloids can be adapted, very readily, for use with medium or light-bodied rubber-base impression materials. With some modification in the mixing technique the results have been very satisfying.

Adaptation of the Syringe - (Hydrocolloid)

1. Remove the rubber insulating cover of the syringe and the syringe tip.

2. Take a 13 gauge needle and cut it off with a disk about one inch from the hub and trim the cut end. (A 13 gauge spinal needle can usually be obtained from the CFMS)

3. Mix some quick cure acrylic and let it stand until it becomes putty-like in consistency.

4. Pack acrylic around the hub of the needle as in figure 1 and insert the hub into the threaded end of the syringe barrel, figure 2. To facilitate removal ensure that the square part of the hub projects above the end of the barrel about 2mm. To force the acrylic into the thread of the barrel, and obtain good adaptation of the acrylic, apply a balanced pressure with the plunger of the syringe and at the same time hold the needle firmly. When the acrylic has partially set, immerse the syringe in hot water to hasten setting.

5. Remove the needle from the syringe barrel by unscrewing and trim the acrylic as necessary.

6. Bend the needle to any desired angle.

1

2

Mixing the Impression Material

1. Before mixing, immerse the two tubes of impression material, glass slab and spatula in cold water and leave for at least ten minutes.

2. Extrude one unit of the white material and three-quarters of a unit of the brown on a cold glass slab. The actual amounts depend on the number of preparations to be covered, but make sure there is enough for both the syringe and the tray.

3. Stir the material with a pen grip until an even consistency is achieved. The manufacturer suggests a 45-second mixing time.

4. To load the syringe, remove the needle, pile the impression material into a heap and place the open end of the barrel into the material and draw up on the plunger. To get better suction in the syringe a coating of silicon grease or vaseline on the plunger washer will help.

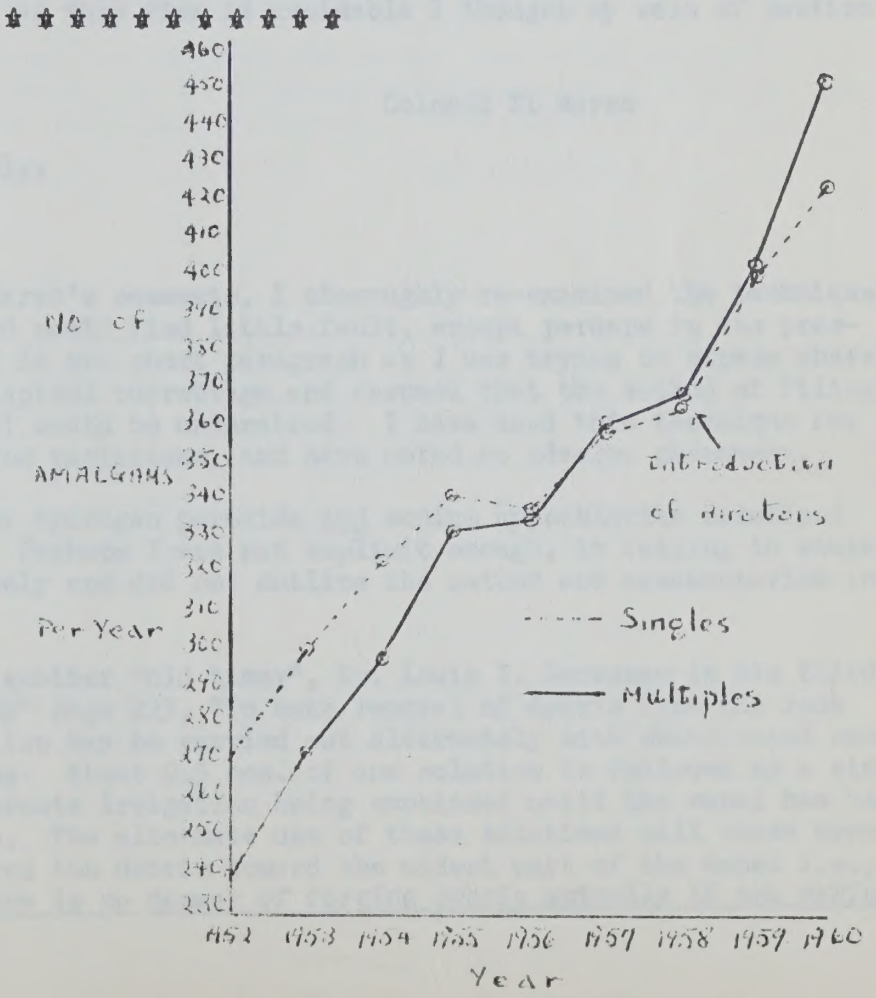
5. Wipe off the barrel and screw the needle into it until tight. The syringe is now ready for use. This mixing technique provides a working time of up to 2½ to 3 minutes, which will be slightly reduced in warmer weather.

Cleaning

1. Immediately after use, have the assistant remove the needle and immerse the syringe, needle, and anything else which may have impression material on it, into warm water to hasten setting.

2. Once set, pull the core of material out of the barrel of the syringe. This may be done easily by using a corkscrew from a silicate liquid bottle. The barrel should then be thoroughly cleaned.

3. To clean the needle, carefully pull the material out. If the needle becomes clogged, a barbed broach is used to remove the material and if this is not successful, replace the needle on the syringe, fill with water and force the plunger down. This usually expels any remaining material.



Progress in Amalgam Production Per Clinically Employed Dental Officer Per Year - 1952-60

LETTERS TO THE EDITOR

Gas-Producing Agents in Apicoectomy Technique

Editorial Board, RCDC Quarterly:

First may I congratulate the Editorial Board on the current issue of the Quarterly. It is improving noticeably with every issue.

If an "old Timer's" professional opinions carry any weight with the younger generation I would like to offer a word of comment on Susser's article re "Apiectomy of Anterior Teeth" on page 18.

In Phase 1 - Root Canal Filling, he advocates flushing the canal with Hydrogen Peroxide 3%. This is fine in cases where no apiectomy is required i.e., where the apical foramen is filled with vital tissue or blood clot. However, as the article refers specifically to cases in which an apiectomy is indicated, it can be assumed that there is an area beyond the apex, the contents of which are unknown.

If in the course of preparation with broaches and files an opening is made through the apical foramen into this area, and if, subsequently some 3% Hydrogen Peroxide gains access to this area and the necrotic material or pus it often contains, the resulting sudden production of a large quantity of gas can produce some very spectacular phenomena in the way of pain and possibly spread of the infection, particularly, if the foramen plugs.

I would suggest that either a non-gas producing flushing agent be used or the flushing with peroxide be carried out with the apiectomy area opened. I know that this sequence of events does not happen often, but when it does the operator will never forget it, believe me! As this risk is avoidable I thought my word of caution might not be out of place.

Colonel TL Marsh

Editorial Board, RCDC Quarterly:

In reply to Colonel Marsh

Upon reading Colonel Marsh's comments, I thoroughly re-examined the technique described in the Quarterly and could find little fault, except perhaps in its presentation. I outlined phase I in one short paragraph as I was trying to stress phase II, i.e., resection and periapical currettage and assumed that the method of filing, flushing and filling the canal would be understood. I have used this technique for the past nine years, with a few variations, and have noted no adverse phenomena.

The article states that hydrogen peroxide and sodium hypochlorite solutions are used to flush the canal. Perhaps I was not explicit enough, in failing to state that these were used alternately and did not outline the method and armamentarium involved.

I would like to quote another "old timer", Dr. Louis I. Grossman in his third edition of "Root Canal Therapy" page 223, "To make removal of debris from the root canal more effective, irrigation may be carried out alternately with chlorinated soda solution and hydrogen peroxide. About 0.5 ccs. of one solution is followed by a similar amount of the other, alternate irrigation being continued until the canal has been completely cleansed of debris. The alternate use of these solutions will cause prompt effervescence and help to force the debris toward the widest part of the canal i.e., toward the pulp chamber. There is no danger of forcing debris apically if the syringe

needle fits the canal loosely since the force of the effervescence will follow the line of least resistance, namely, toward the mouth of the canal and into the pulp chamber." $H_2O_2 + NaOCL \longrightarrow NaCl + H_2O + O_2$). As H_2O_2 also liberates oxygen on contact with debris in the root canal it is reasonable to expect that the foaming action will force debris toward the mouth of the canal as described by Grossman.

Many other agents used in flushing the root canal are also gas producers, viz., sodium hypochlorite used alone liberates chlorine; so does azochloramide which does so perhaps more slowly. I see no reason to cease using these gas producing agents so long as the technique is correct.

It is agreed that it would be unwise to introduce any gas producing agent into a canal where pus is present but this is not done. There is really no great mystery as to the contents of a periapical area. If pus is present, it will usually well up and flow out when the chamber and root canal are opened. Presence of pus indicates necrosis and in these cases, the canal is left open to drain for several days until drainage has ceased. We can then safely assume that granulation has commenced and if the tooth is asymptomatic proceed with the root canal treatment of choice. It must be pointed out that granulation tissue is not necrotic but is in fact an effort at healing. The formation of a granuloma is indicative of a defensive reaction on the part of the periapical tissue (Schour). Granulation tissue is hard to infect because it is mobilized to meet bacterial invasion (Boyd Textbook of Pathology). Although a small radicular cyst cannot always be differentiated on X-ray from a granuloma; in most cases such differentiation is possible. Thus the operator in most instances can know the type of periapical tissue he has to deal with.

I have tried the technique of opening into the periapical area before treating the root canal and have found it messy. It is very difficult to establish a clean, dry canal with blood from the periapical area seeping into it.

In conclusion may I thank the editorial board for their fine editing of my article so as to make it readable. It is unfortunate however, that the X-rays submitted could not be printed as they would substantiate the technique more than a thousand words.

Major IW Susser

In Support of Replantation

Editorial Board, RCDC Quarterly:

With reference to the article "The Case for Replantation" by Major DE McDermott and Capt WF Shaw in the Royal Canadian Dental Corps Quarterly, Volume 2 Number 1, April 1961, I report a case of interest. It concerns the replantation of the upper right central incisor for Sgt Garbutt KC, SB 153350. I replanted this tooth in Aug 1949 at Camp Borden. In Oct 1959 I received a letter from Major JC Hughson, retired, and I quote, "Clinically, the tooth is slightly discoloured, but is otherwise symptomless. There is good gingival attachment and it was impossible to probe into the radiolucent areas on the mesial and distal."

Major AG Andrews

Editor's Note: Letters to the Editorial Board are welcome and will be published if they are of general interest to members of the Corps.

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NEW OFFICERS IN THE CORPS

A special welcome is extended to our ten new officers. It is hoped that their stay in the Corps will be a happy one and that many will see fit to make the RCDC a permanent career.

Capt MA Abramson, DDS, a Toronto graduate, has been posted to No 12 Coy and is employed at HMCS Cornwallis. Although born in Montreal, Capt Abramson spent most of his life in the United States and completed three years of dentistry at the University of Pittsburgh before transferring to U of T for his final year.

Capt HW Brogan, DDS, of Minto, N.B. is a Dalhousie graduate and commences his career with No 14 Coy at Fort Churchill.

Capt MN Deyette, DDS, a native of Parry Sound, Ont graduated from the University of Toronto and is posted to Camp Petawawa.

Capt JGB Dionne, BA, DDS, of Montreal and a graduate of the University of Montreal will start his career in the far west at RCAF Station Comox, B.C.

Capt AG Garden, DDS, of Saskatoon and Rolling Hills, Sask is the only University of Alberta graduate amongst the new officers. He has been posted to 11 Coy and will be employed in Calgary.

Capt JFA Marcil, BA, DDS,of Montreal and a graduate of Montreal has been posted to Montreal.

Capt KSM Mathers, DDS, of Kitchener, a University of Toronto graduate, has been posted to RCAF Stn Rockcliffe.

Capt AL Moran, DDS, a native of Port Arthur and a graduate of the University of Toronto starts his career at RCAF Station, Downsview, Ont.

Capt RJ Paturel, BSc, DDS, of Halifax and a Dalhousie graduate is posted to another seaport, Fort Churchill.

Capt PP Prud'Homme, BA, DDS, of St Jerome, Que graduated from the University of Montreal and has been posted to Camp Valcartier.

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RETIREMENTS AND RELEASES

During the three months since the last issue of the Quarterly, a number of officers and men have reached retirement age or have taken releases from the Corps to enter private practice. Although we are sorry to see them go, all members of the Corps wish them happiness and success for the future.

Retirements

Col HL (Hum) Harris, CD, DDS, QHDS, who vacates the appointment of Director of Dental Services (Navy) in the Directorate of Dental Services has been with the Corps for 22 years. He was born in Freeport, N.S. and educated in Yarmouth, N.S. and at Dalhousie University. He obtained his DDS degree at McGill in 1934 and following a year's internship in Oral Surgery in Montreal hospitals, entered private practice in Kentville, N.S.

Commissioned in the CDC in November 1939, he proceeded overseas in 1942 and saw service in the UK and Northwest Europe. On his return to Canada in 1945 he was posted to Vancouver, B.C. Since the war he has held various appointments in Ottawa, Trenton and Halifax. He was promoted Lt Col in 1949 and to his present rank in 1956.

Col Harris who is married with two children has accepted an appointment as Chief Dental Officer of the Department of Education in London, Ont.

Col TL (Tommy) Marsh, CD, DDS, DDPH, at the time of his retirement was Command Dental Officer Quebec Command and Commanding Officer, No 15 Dental Coy, Montreal. He has seen 19 years' service with the Corps. Born in England, he moved to Canada at an early age. He received his dental education at the University of Toronto in 1932 and attended the same university again in 1952 to receive his DDPH.

He enrolled in the CDC in 1942 and during the war served in Canada and the UK as well as at sea aboard HMCS Warrior. Since the war he has served as an instructor at The RCDC School, as Commanding Officer of No 1 Field Dental Coy in Germany, Dental Public Health Officer at Army Headquarters and assumed his present appointment in 1958. Active in medical and dental research, Col Marsh is a member of the American Medical Editors and Authors Association, Member of the Executive Council of the Toronto Academy of Dentistry, Past President of the Alumni of the Newman Club, U of T, as well as having a wide interest in journalistic and research committees.

Col Marsh who is married with two children has accepted a civilian post with the Provincial Government of Manitoba and will reside in Winnipeg.

Capt NS (Norm) Gage, CD, DDS, who prior to his retirement was dental officer at Royal Military College, Kingston, has served 16 years with the Corps. He was born in Kingston and received his public and high school education there and graduated from the University of Toronto with his DDS in 1933, following which he returned to Kingston to enter private practice. He enrolled in the CDC in 1939 and during the Second World War served in Canada, UK and Northwest Europe until December 1945. He was then employed by the Department of Veterans Affairs in Kingston until 1951 when he was again commissioned in the Corps and since that time has had postings in Prairie and Central Commands.

Capt Gage who is married with one daughter has accepted a hospital appointment in Kingston with the Provincial Government of Ontario.

Releases

The following officers have entered private practice on completion of their tours of duty with the Corps:

Capt	JS	Davis
Capt	CJL	Dorval
Capt	LA	Reynolds
Capt	GG	Tremblay

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POSTINGS

Summer time is posting time and this year is no exception in the Corps. The following movement of personnel has taken place since the last issue of the Quarterly:

Colonel BP Kearney formerly Commandant, The RCDC School has been posted to Edmonton as Command Dental Officer, Western Command and Commanding Officer, No 11 Coy.

Colonel IAL Millar formerly CO No 11 Coy has replaced Colonel HL Harris on the staff of the Directorate of Dental Services in Ottawa.

Colonel CE Purdy has vacated the appointment of CO No 14 Coy and is now Commandant, The RCDC School.

Lt Col JG Butler has been posted from the Directorate of Dental Services' staff to become Command Dental Officer, Quebec Command and CO No 15 Coy.

Lt Col GR Covey who has been CO No 35 Fd Dent Unit in France for the past three years replaces Lt Col Butler on the Directorate Staff.

Lt Col LG Craigie has been posted to command No 35 Fd Dent Unit following five years as an instructor in operative dentistry at The RCDC School.

Lt Col RB Jackson formerly the Senior Dental Officer in the Ottawa area has been appointed Commanding Officer of No 14 Coy.

Maj	FD	Charman	-	to 35 Fd Dent Unit from Griesbach Bks, Edmonton
Maj	RA	Fell	-	to Goose Bay from HMCS Naden, Esquimalt, BC
Maj	IAC	MacDonald	-	to Calgary from 35 Fd Dent Unit
Maj	JCE	McDonald	-	to Edmonton from CBUME
Maj	FM	Nesbitt	-	to RCSME, Chilliwack, BC from RCAF Stn Winnipeg
Maj	LA	Richardson	-	to RCAF Stn Winnipeg from RCAF Stn Namao, Edmonton
Maj	EJC	Small	-	to CBUME from Oakville, Ont
Maj	JM	Smith	-	to Treatment Wing, The RCDC School from Goose Bay
Capt	JF	Begin	-	to RCAF Stn Goose Bay from Quebec City
Capt	GIJ	Bisaillon	-	to 14 Coy from 4 Fd Dent Coy in Germany
Capt	RD	Bunt	-	to CBUME from Winnipeg
Capt	JF	Eadon	-	to RCAF Stn Penhold from Fort Churchill
Capt	BA	Gaudet	-	to Quebec City from CBUME
Capt	LC	Gray	-	to Vancouver from Calgary
Capt	RH	Headley	-	to 4 Fd Dent Coy from RCAF Stn Parent, Que
Capt	MAJ	LaChapelle	-	to HMCS Bonaventure from Camp Petawawa
Capt	HK	Meisner	-	to 35 Fd Dent Unit from HMCS Cornwallis
Capt	DJ	MacPhee	-	to 4 Fd Dent Coy from RCAF Stn Downsview
Capt	M	Petryk	-	to Calgary from RCAF Stn Cold Lake
Capt	JCRR	Roy	-	to RCAF Stn Parent from Montreal
Capt	JJY	Turcotte	-	to 35 Fd Dent Unit from RCAF Stn Goose Bay
Lt	HF	Doyle	-	to 14 Coy HQ, Winnipeg from Camp Petawawa
Lt	EL	Proudfoot	-	to 11 Coy HQ from the Directorate of Dental Services, Ottawa
WO1	TA	Jones	-	to DGDS, Ottawa, from Winnipeg
WO1	WD	Morris	-	to 1 Dent Eqpt Dep, Petawawa from The RCDC School
WO2	JR	Card	-	to 14 Coy HQ, Winnipeg from DGDS, Ottawa
WO2	MB	Fisk	-	to DGDS from Camp Petawawa
WO2	WW	McMichael	-	called out HMCS Naden, Esquimalt, BC
WO2	RWM	Hall	-	to RCDC Schl from No 1 Cl, AFHQ, Ottawa

WO2	EC	Carpenter	- to The RCDC Schl from 11 Coy QM Stores, Calgary
WO2	JE	Shiner	- to HMCS Cornwallis from No 1 Cl, AFHQ, Ottawa
Ssgt	MF	Conkey	- to 11 Coy QM Stores, Calgary from Camp Petawawa
Sgt	DD	Casson	- to RCAF Stn Moose Jaw from Winnipeg
Sgt	WF	Chase	- to Camp Gagetown from HMCS Bonaventure
Sgt	RD	D'Eon	- to 4 Fd Dent Coy from HMCS Naden, Esquimalt, BC
Sgt	DLG	Flesher	- to 4 Fd Dent Coy from DGDS, Ottawa
Sgt	RG	Hopkins	- to RCAF Stn St Jean, Que from Camp Petawawa
Sgt	VR	Kidd	- to Whitehorse from Edmonton
Sgt	HC	Kirby	- to HMCS Cornwallis from HMCS Stadacona, Halifax
Sgt	EE	Mazerall	- to Pers RCDC, Ottawa from Edmonton
Sgt	JM	Moore	- to Calgary from Whitehorse
Sgt	FK	McKay	- to HMCS Bonaventure from Camp Gagetown
Sgt	MO	McDonald	- to 4 Fd Dent Coy from RCAF Stn Goose Bay
Sgt	RH	Palmer	- to Edmonton from 4 Fd Dent Coy
Sgt	SE	Robertson	- to RCAF Stn Goose Bay from Workpoint Bks, Esquimalt
Sgt	AJ	Tait	- to Camp Petawawa from RCAF Stn Centralia
Sgt	JM	Tapp	- to RCAF Stn St Jean, Que from The RCDC School
Sgt	HEW	Reid	- to CBUME from HMCS Cornwallis
Sgt	SM	Toole	- to HMCS Naden, Esquimalt from 4 Fd Dent Coy
Sgt	JA	Shields	- to Esquimalt from 4 Fd Dent Coy
Sgt	G	Shechosky	- to Winnipeg from Saskatoon
L/Sgt	G	MacCuish	- to HMCS Stadacona from CBUME
Cpl	JIJ	Boulanger	- to CBUME from Longue Pointe, Montreal
Cpl	JWW	Broomfield	- to RCAF Stn Cold Lake from CBUME
Cpl	HK	Drawe	- to CBUME from Edmonton
Cpl	PJ	Dumas	- to Camp Petawawa from RCAF Stn Trenton
Cpl	EA	Duve	- to Camp Petawawa from Calgary
Cpl	P	Fox	- to Esquimalt from Edmonton
Cpl	SG	Harmer	- to Vancouver from CBUME
Cpl	EJ	Lansey	- to 4 Fd Dent Coy from Quebec City
Cpl	CM	Martell	- to CBUME from HMCS Stadacona
Cpl	SR	Monahan	- to RCAF Stn Cold Lake from The RCDC School
Cpl	AF	Randall	- to HMCS Stadacona from HMCS Cornwallis
Cpl	GD	Schwarze	- to Whitehorse from Edmonton
Pte	RL	Geddes	- to Camp Petawawa from Camp Ipperwash
Pte	BA	Green	- to Edmonton on transfer from the C Pro C
Pte	PA	McCoy	- to HMCS Naden on transfer from 1 Bn PPCLI
Pte	DH	McKay	- to RCAF Stn Trenton on transfer from PPCLI Depot
Pte	PD	Peterson	- to Camp Gagetown from RCAF Stn Cold Lake
Pte	WW	Webster	- to RCAF Stn Penhold from Edmonton

Airwomen

LAW	EE	Dennis	- to RCAF Stn Goose Bay from RCAF Stn St Jean
LAW	ML	Dubuc	- to RCAF Stn Greenwood from Goose Bay
AW1	DF	Adams	- to RCAF Stn Cold Lake from St Jean
AW1	CMR	Barbor	- to RCAF Stn Aylmer from St Jean
AW1	DL	Carroll	- to RCAF Stn Trenton from St Jean
AW1	JM	Giacobbo	- to RCAF Stn Camp Borden from RCAF Stn Parent
AW1	DJ	Hollins	- to 35 Fd Dent Unit from St Jean
AW1	KY	Keddy	- to RCAF Stn Summerside from Goose Bay
AW1	MG	Poulson	- to RCAF Stn Camp Borden from St Jean
AW1	ME	Reddy	- to RCAF Stn Trenton from St Jean
AW1	A	Skubiak	- to RCAF Stn Winnipeg from Parent
AW1	HI	Walko	- to RCAF Stn Portage la Prairie from St Jean
AW1	LA	Wiens	- to RCAF Stn Goose Bay from St Jean
AW1	LP	Yakemchuk	- to RCAF Stn Parent from RCAF Stn St Hubert

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PROMOTIONS

Congratulations are extended to the following officers and men on their recent promotions:

Lt Col	CE	Purdy	- promoted to	Colonel
Lt Col	AT	Roger	- " "	Colonel
Maj	DH	Hillier	- " "	Lt Col
Maj	G	MacDougall	- " "	Lt Col
Capt	JI	Gordon	- " "	Major
WO 1	EA	Church	- " "	Lt
WO 2	WD	Morris	- " "	WO 1
Ssgt	EK	Abernethy	- " "	WO 2
Ssgt	AJ	Arsenault	- " "	WO 2
Ssgt	AJ	Greco	- " "	WO 2
Ssgt	SL	MacLean	- " "	WO 2
Ssgt	EB	Morse	- " "	WO 2
Ssgt	JM	Sherry	- " "	WO 2
Sgt	EMB	Everett	- " "	Ssgt
Sgt	GEC	Bradley	- " "	Ssgt
Cpl	FK	MacKay	- " "	Sgt
Cpl	RF	Matheson	- " "	Sgt
Cpl	EL	Schell	- " "	Sgt
Cpl	GW	Wilkinson	- " "	A/Sgt
Cpl	GH	Taylor	- " "	A/Sgt
Cpl	KPH	Buchholz	- " "	A/Sgt
Cpl	G	MacCuish	- " "	L/Sgt
Pte	GD	Schwarze	- " "	Cpl
Pte	GM	Wadden	- " "	Cpl

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VITAL STATISTICS

DIRECTORATE OF DENTAL SERVICES

Sickness:

Miss Pat Curtin, the Director's secretary, has returned to work after 11 days in hospital and three weeks' sick leave.

Miss Ruth Victor, our stenographer, has also returned to work after a two-month absence during which time she spent 10 days in hospital for surgery.

Marriages:

Miss Marie Leduc was married in Rockland, Ont on 1 Jul 61 to Mr. Denis Thivierge of Rockland.

NO 1 DENT EQPT DEP

Sickness:

Ssgt Davison's wife Betty was hospitalized for surgery on 10 Apr and is now well on her way to recovery.

Miss Rita Little, a member of the Depot Staff, who underwent surgery on 16 Apr has returned to duty.

THE RCDC SCHOOL

Births:

To Lt Col and Mrs JW Turner on 31 May 61, a son, Daniel Brian.
To Sgt and Mrs Glen Jennings on 13 Apr 61, a son, Steven Douglas.

NO 11 DENT COY

Marriages:

Cpl AH Green was married in Calgary on 1 Apr 61 to Miss Mary Ann Couch.

Births:

To Major and Mrs JJ Walker on 14 May 61, a son, Stephen Edward.
To Capt and Mrs WT Harley on 8 May 61, a daughter, Leslie Dale.
To Capt and Mrs PP Morin on 30 May 61, a son, Peter Wayne.

12 DENT COY

Sickness:

Capt "By" Johnston has been in and out of hospital a number of times in the past several months. We are hoping for a complete recovery and return to full-time duty soon.

Ssgt Alex McIsaac and Sgt Doug Murley were both unfortunate in having to spend a month in hospital. Both will be returning for continuing treatment.

Former Capt "Moe" Harquail was released from hospital here after an internal operation. Since leaving the Corps "Moe" has had several illnesses and an office fire. We can only hope that his misfortunes are now ended.

13 DENT COY

Marriages:

Captain KSM Mathers was married in Toronto on 3 Jun 61 to Miss Frances Halfall of Scarborough. Mrs Mathers is a graduate of the University of Toronto and the Ontario College of Education and plans to teach physical education at Eastview High School.

Births:

To Capt and Mrs RA Bell on 27 Mar 61, a daughter, Donna Jane.
To Capt and Mrs. GR Myles on 8 Apr 61, a daughter, Jacqueline.
To Ssgt and Mrs JCA Therrien on 31 May 61, a son, Joseph Adrien Patrick.
To Cpl and Mrs TW Thrasher on 7 Apr 61, a son, David Philemon.
To Pte and Mrs RH Stenabaugh on 30 May 61, a son, Richard Hartley.

Hospital:

Lt Col	WW	Anglin	-	6 - 17 Jun 61
Maj	JG	Andrews	-	23 May - 2 Jun 61
Capt	JW	Lincoln	-	17 Apr - 3 May 61
Ssgt	WB	Weir	-	22 Jan 61 -
Cpl	WE	Bussell	-	3 - 21 Apr 61
Cpl	JEN	Boucher	-	9 - 10 Apr 61
Cpl	JRE	Lalonde	-	29 May - 15 Jun 61
Cpl	HM	McCurdie	-	5 - 11 Apr 61

14 DENT COY

Deaths:

AW 1 MH Newton, a dental assistant at RCAF Station Portage la Prairie was the victim of a fatal highway accident on the week-end of 9 Apr 61.

Births:

To Capt and Mrs JJPH Houle on 9 Mar 61, a daughter, Marie Pauline Sylvia.
To Capt and Mrs JR Boulay on 13 Apr 61, a daughter, Marie Diane Manon.
To Sgt and Mrs A Bramble on 4 May 61, a daughter, Sharyl Elizabeth.

Sickness:

Sgt A Bramble was admitted to Deer Lodge Hospital in Winnipeg on 3 Apr and returned to duty 10 Apr 61.

Ssgt AH Nixon underwent surgery at Deer Lodge Hospital on 23 Apr 61. He returned to duty on 9 May 61.

Sgt WD MacDougall was admitted to Deer Lodge Hospital for surgery on 20 Apr 61. He returned to Fort Churchill on 8 May 61.

15 DENT COY

Births:

To Capt and Mrs JFA Marcil, a daughter, Marie Fernande Sylvie.
To Capt and Mrs JR Senechal, a son, Joseph Claude.
To Sgt and Mrs MD Crockett, a daughter, Sandra Lee.

35 FD DENT UNIT

Marriages:

Cpl ME Clark was married to LAC D Jensen on 3 Jun 61.

Births:

To Major and Mrs AL Kelland on 22 Apr 61, a daughter, Laura Jane.

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TRAINING

During the period since 1 May covered by this issue of the Quarterly, Corps personnel have successfully completed a variety of training as follows:

US Naval Dental School, Bethesda, Md

Maj	ED	McDermott	- 12 Coy	-	Crown & Bridge	- 5 days
Capt	HG	Bunston	- 12 Coy	-	Complete Dentures	- 5 days
Capt	JT	Marshall	- 12 Coy	-	High Speed Orientation	- 5 days

The RCDC School

Dental Technician Clinical - Group 3

Sgt	HEE	Franzgrote	- 11 Coy
Sgt	RG	Pelletier	- 12 Coy
Sgt	JM	Tapp	- 13 Coy

Dental Technician Laboratory - Group 1

Cpl	JC	Bleakney	- 12 Coy
Cpl	EB	Borden	- 13 Coy
Cpl	H	Chamberlain	- The RCDC School
Cpl	G	Dancer	- 15 Coy
Cpl	PAP	Hughes	- 12 Coy
Cpl	SR	Monahan	- 11 Coy
Pte	CS	Sabine-Pasley	- 13 Coy
Pte	RH	Stenabaugh	- 13 Coy
Cpl	AE	Werkmann	- 15 Coy

Dental Assistant - Group 1

Pte	OW	Mandrusiak	- 13 Coy
Pte	DB	Loosely	- 13 Coy
Pte	A	Pink	- 12 Coy
Pte	WW	Webster	- 11 Coy
LAW	EE	Dennis	- 15 Coy
AW1	KY	Keddy	- 15 Coy
AW1	LP	Yakemchuk	- 15 Coy
AW1	LA	Wiens	- 15 Coy
AW1	FR	Peck	- 15 Coy
AW1	GT	Coen	- 12 Coy
AW1	YML	Fournier	- 13 Coy
AW1	MJD	Fisher	- 13 Coy
AW2	MR	Thibault	- 15 Coy

25 TO POST ORDER

Marriage

Cpl RS Clark was married on 5th [illegible] on 3 June 61.

Births

To Major and Mrs RL Ballard on 20 Apr 61, a daughter, Sheila Jane.

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TRAINING

During the period above 1 Sqn ceased to [illegible] Wing of the Battalion, three personnel have successfully completed a variety of training as follows:

22 Naval Patrol School, Portsmouth UK

Maj	RD	Ballantyne	- 12 Sqn - Course [illegible]	-	3 days
Capt	MO	Emerson	- 12 Sqn - Tactical Doctrine	-	3 days
Capt	VT	Bennett	- 12 Sqn - Anti Naval Duties	-	3 days
			Indian	-	3 days

The RCAF School

Naval Technician Clinical - Group 1

Sgt	RDE	Pennycuick	- 12 Sqn
Sgt	RO	Pellerin	- 12 Sqn
Sgt	VA	Tapp	- 12 Sqn

Naval Technician Laboratory - Group 1

Cpl	JO	Blakney	- 12 Sqn
Cpl	RO	Gordon	- 12 Sqn
Cpl	E	Chamberlain	- The RCAF School
Cpl	O	Lacour	- 12 Sqn
Cpl	EJP	Hughes	- 12 Sqn
Cpl	RM	Moreau	- 12 Sqn
Pte	CS	Gobbe-Hartop	- 12 Sqn
Pte	DR	Greenough	- 12 Sqn
Cpl	AE	Hartmann	- 12 Sqn

Naval Analyst - Group 1

Pte	DW	Macdonald	- 12 Sqn
Pte	DR	Cooney	- 12 Sqn
Pte	A	Plok	- 12 Sqn
Pte	RW	Webster	- 12 Sqn
LCP	EE	Jacobs	- 12 Sqn
AC1	EJ	Kelly	- 12 Sqn
AC1	EJ	Tolmenton	- 12 Sqn
AC1	EA	Wiebe	- 12 Sqn
AC1	PT	Pace	- 12 Sqn
AC1	GC	Cann	- 12 Sqn
AC1	TJG	Forester	- 12 Sqn
AC1	EJD	Brown	- 12 Sqn
CPO	EO	Mitchell	- 12 Sqn

Dental Assistant - Group 1 (cont'd)

AW2	DL	Carroll	- 15 Coy
AW2	ME	Reddy	- 15 Coy
AW2	HI	Walko	- 15 Coy
AW2	DF	Adams	- 15 Coy
AW2	CMR	Barbor	- 15 Coy

The RCASC School

Senior NCO Course

A/Sgt	GH	Taylor	- 11 Coy

Command Junior NCO School

Jr NCO Course

A/Cpl	GD	Schwarze	- 11 Coy

CFMSTC

First Aid Instructor (Tri-Service)

Cpl	WA	Jackson	- The RCDC School

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DIRECTORATE NEWS

Brigadier Baird Visits Europe

Brigadier KM Baird, Director General of Dental Services and Mrs Baird returned to Canada on 14th July following a month in Europe. During this tour, the Director General inspected RCDC facilities and interviewed officers and men of No 35 Fd Dent Unit and No 4 Fd Dent Coy. He also presented a paper to the Armed Forces Dental Services Commission of the Federation Dentaire Internationale in Helsinki, Finland and visited London to confer with Major-General H Quinlan, Director of Army Dental Service, RADC, Surgeon Rear-Admiral (D) W Holgate, Director of Dental Services, RN, and Air Vice-Marshal R Scoggins, Director of Dental Services, RAF.

Farewell Party for Col Harris

The Army Headquarters Officers' Mess was the site for a farewell party on 26th May tendered Col and Mrs "Hum" Harris by officers of the Directorate and clinics in the Ottawa area and their ladies. The popularity of the Harris' was reflected in the large turnout of local officers and the presence of militia officers and visitors from 13 Coy, 15 Coy and The RCDC School.

Following a short speech, Brigadier Baird presented, on behalf of the officers present, a suitably engraved rose bowl and the set of dice used to determine postings for Corps personnel.

Col and Mrs Harris are now vacationing in Nova Scotia prior to their move to London in August.

Col Millar in Camp Borden

Col IAL Millar visited Camp Borden recently to interview undergraduates taking summer training at The RCDC School.

Maj Brick to Gagetown

Maj JC Brick spent three days in Camp Gagetown in July to observe Corps operations in the field.

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RCDC SCHOOL NEWS

School Wins Meds-Dents Volleyball Championship

On 2nd March The RCDC School Volleyball Team won the 1960-61 Medical-Dental Intra-Mural Volleyball Championship. The six-team league operated through the winter months with games being played on Thursday afternoons. Stiff opposition was provided by two or three of the Medical teams but the stalwarts in green warded off all contenders to finish first in the league standings. In the semi-finals and finals 4 Fd Amb RCAMC threatened to take the laurels away but the Dentals rallied and were not to be denied.

Congratulations to the team on such a fine season and for adding the Volleyball Trophy to the School's list of achievements in sports around Camp Borden.

Front Row L to R

Bill Jackson, Jack Jones, Glen Jennings

Back Row L to R

Arnold Semple, Marcel Tapp, George Bradley, Tom Batten

RCDC School Annual Golf Tournament

Thursday, 25th May saw a new champion crowned as once again the staff of The RCDC School took to the fairways for their Annual Golf Tournament. At the end of the first nine, it was apparent that an upset was in the making as our perennial "Pro" Capt Chas Casterton was off his usual form and when the scores were tallied after eighteen holes, he was down one stroke to Capt Van Ryssel the new winner and holder of the Fletcher Trophy for 1961. Col Kearney as well as Major Jim Wright also made a very strong bid for the title but ended up a stroke or two off the pace. Winners of other awards for the "hidden hole" etc were Lt Col Bagnall, Maj Jack Craig, Sgt Bill Richardson and Sgt Jack Sadler. Two of the feature winners on the front nine, Lt Col Bagnall and Maj Craig are shown waiting at the first tee with other members of the School's "fearsome foursome" Lt Col Jay Turner and Major Bill Thompson. As predicted after last year's tournament, Lt Col Turner is rapidly developing into the School's "long ball" hitter but this is probably only because we have finally convinced him to start using balls with covers on them.

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NO 1 DENT EQPT DEP NEWS

Farewell Party for Departing Personnel

A combined No 3 Dental Clinic and No 1 Dent Eqpt Dep party was held in the lounge of the new Recreation Building, Camp Petawawa on 25th May to honour Capt Mark LaChapelle, Lt Herb Doyle, WO 2 Maxie Fisk, Ssgt Merv Conkey and Sgt Ray Hopkins who are posted from this area. In spite of the fact that Capt LaChapelle was unable to attend because of car trouble, the party was a huge success.

Sports

On the evening of 21st June a challenge softball game was played between members of this unit and No 3 Clinic. Although the final score was 21 to 14 in favour of the clinic everyone enjoyed the outing and a return match has been slated.

Inspection

Colonel HM Cathcart, Commander of Camp Petawawa carried out his annual inspection of the unit on 31st May. All personnel were on parade and the Commander expressed satisfaction with the state of the unit.

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11 DENT COY NEWS

Canadian Dental Association Convention

Col IAL Millar, Maj RA Fell, Maj HR Kettyls, Maj MP Quinn and Maj LA Richardson attended the CDA Convention at Saskatoon 4 - 7 Jun 61. All were loud in their praises of the tone and organization of the proceedings.

Trooping of the Colour

RCDC personnel in the Victoria and Edmonton areas were impressed with the ceremonies attendant upon the Trooping of the Colours of the 1st and 2nd Bn PPCLI on 13th May and 10th June respectively.

Farewell Parties

Col Millar's off duty hours during the final few weeks in this unit were well taken up with farewell entertainment provided by a host of military and civilian friends. Similarly, farewell "dos" have been held for all other personnel proceeding on postings.

Duty Trips

Capt M Petryk, Sgt WJ Arnsby and Cpl J Dion provided treatment to service personnel and dependents at Ft Nelson, BC, 19 - 29 Jun 61.

Cpl JG Moore on temporary duty QM Stores in Calgary typing the Board for the Change of Command from Col IAL Millar to Col BP Kearney.

Lt Col GE Shragge (Ret) on temporary duty from Workpoint Bks, Esquimalt to RCAF Penhold and RCSME Vedder Crossing during the period Jun - Jul 61.

Capt JO Bowman, Sgt GH Storms and Cpl RJ Lowery proceeded to RCAF Holberg 12 Jun 61 for a period sufficient to complete dental requirements.

Ssgt H Hodkinson and Sgt VR Kidd relieved the dental assistant situation at RCAF Penhold during their TD trips from 24 Apr - 7 May and 8 May - 22 May 61 respectively.

Col IAL Millar has made his final inspection visits to the various clinics throughout the unit during the past few months.

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12 DENT COY NEWS

Sports

Capt Hal Bunston continued his good work for the Shearwater Flyers' Volleyball Team - helping them win the Eastern Canada Tri-Service Championship and a fourth place finish in the Eastern Canada Open Championship in Toronto in April.

Maj Gordon Throws Steak Party

Major "Ike" Gordon gave a STEAK party at the RA Park Officers' Mess for all officers in the Halifax Area to celebrate his promotion to Major. An impromptu gathering was held for all ranks before dinner.

Farewell Party for Sgt Marchand

A farewell party was held at the Grn Sgts' Mess in honour of Sgt Francis Marchand who will soon be proceeding on posting to No 35 Fd Dent Unit for employment at Marville, France.

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13 DENT COY NEWS

Duty Trips

Col AC Leman recently inspected dental clinics and visited the various headquarters in Eastern Ontario Area, Central Ontario Area and Western Ontario Area.

With the departure of seven dental officers and one dental technician laboratory from this unit, Capt Hunter, our Quartermaster, has had a fairly busy time scooting about the province checking out their dental kits.

Capt Gage at RMC Graduation Ceremonies

Capt NSA Gage, who retired from the RCDC in June, is seen here suitably attired in the gown indicative of graduation from the University of Toronto, at the 1961 RMC graduation ceremonies. Capt Gage has been the dental officer on the staff of RMC for the past several years.

Attend ODA Convention

Col AC Leman, Lt Col RHG Cunningham and Majors Chatwin, Pierce and Falkner officially attended the Ontario Dental Association Convention in May and took part in the presentation of the RCDC Exhibit.

13 Coy Clinic Day at Kingston

A highly successful Dental Clinical Day was held in the auditorium of the Canadian Forces Hospital Kingston in April and was attended by selected dental officers of No 13 Dental Coy located in Eastern Ontario Area. The following interesting papers were presented:

Points to Remember in Endodontics	- Lt Col RHG Cunningham, DDS
Management of the Fractured Maxilla - Case Report	- Major AG Andrews, DDS
Biopsies and Specimens	- Dr HD Steele, MD
Pain Associated with Sinuses and Teeth	- Lt Col TC Fort, MD
Radiation Injury	- Major WH Levis, MD
The Dentist and the Cardiac Patient	- S/L GL Fitzgibbon, MD
Expired Air Resuscitation with Particular Reference to the Dentist - With a Film	- Surg Capt MH Little, MD
Lesions of Periodontal Disease	- Lt Col WW Anglin, DDS
Surgical Correction of the Prognathic Mandible	- Colonel AC Derby, MD Major JVP Chatwin, DDS
Treatment of Trauma in Mass Casualties	- Colonel AC Derby, MD

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14 DENT COY NEWS

Col Purdy Visits Fort Churchill, Ottawa and Saskatoon

Col CE Purdy made a liaison visit to HQ Fort Churchill on 24 and 25 Apr 61 and inspected the dental facilities at that Station. He also attended the Stores Committee Meeting at the Directorate from 26 to 29 Apr 61. During 4 to 7 Jun 61 he represented the DGDS at the Canadian Dental Association and Western Canada Dental Society Convention in Saskatoon, Sask and on this occasion addressed the Canadian and Western Canada Nurses' and Assistants' Association on "Scientific Facts of Interest to Dental Nurses".

Farewells Given Col Purdy, Capt Cook and WO 1 Jones

On 19 May 61 a unit all ranks' mixed party was held in the LaVerendrye Officers' Mess by 57 Dental Unit(Militia). On invitation from Lt Col MJ Snidal, Commanding Officer of 57 Dent Unit, many couples from 14 Dent Coy attended. The evening was devoted to dancing and a delicious buffet supper was served.

During the course of the evening Col Purdy and Capt Dave Cook were honoured by the presentation of suitably inscribed silver mugs to mark the occasion of their departure from Winnipeg. Their ladies were presented with a beautiful corsage of roses.

The staffs of Coy HQ and the Fort Osborne Barracks clinic gathered together on 25 May 61 to bid "good-bye and good-luck" to WO 1 Al Jones who departed via annual leave to take up his new position in DGDS. Col Purdy on behalf of the staffs, presented Al with a travelling clock as a memento of the unit.

14 Coy Sports

The 14 Coy RCDC Bowling League concluded its activities in Apr 61 after a most successful season. Six teams, comprising players from RCDC personnel in Winnipeg and 57 Dental Unit (M) participated. Interest was keen and competitive as the play progressed. Capt Jacques Boulay's team took an early lead which was maintained throughout the season winning the Ash Temple Trophy only to be beaten in the finals by a team captained by Ben Gareau. This latter team was presented with the fine "Purdy Trophy" donated by Col CE Purdy and emblematic of league championship.

The season closed with a dinner-dance at the Fort Garry Hotel which was well attended. Trophies were presented during the course of the evening.

The league members expressed a hearty vote of thanks to the committee comprising WO 1 Ben Gareau, Cpl Frank Reid and Cpl Don Fenton.

A new committee was elected for the 1961-62 season, consisting of Sgt Keith Laurence, President; Cpl Frank Reid, Secretary and Capt Jacques Boulay, Treasurer.

Clinic Personnel - Fort Churchill

Left to Right:

Sgt Bill MacDougall, Sgt Art Bramble, Cpl Dick Walker
Capt Claude Arpin, Miss Bonneau, and Maj Jim Jolly

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15 DENTAL COY NEWS

Farewell Party to Honour Col Marsh

Over fifty members of 15 Dent Coy assembled at RCAF Station St Jean on the evening of 17th June to honour Colonel TL Marsh on the occasion of his retirement from the Corps. Lt Col AR Smith presented the retiring CO with a farewell gift on behalf of the personnel of the unit, to which Col Marsh replied in his usual eloquent manner. Three rousing cheers and the singing of "Auld Lang Syne" left the Colonel a little misty-eyed but recovery was hastened by the sight of a sumptuous buffet dinner supervised by the "gourmet" of the unit, Capt Jacob. We sincerely wish Col Marsh the very best in his new appointments as Professor in the Faculty of Dentistry at the University of Manitoba and as District Superviser of Dental Public Health in the Province of Manitoba.

Sports

Lt Col Butler and Capt Harrison represented 15 Dent Coy in the HQ Que Comd June Golf Tournament but their quest for prizes, fame and glory was unsuccessful. Major Guevremont, Capt Parent and Capt Jacob have also chosen golf as their summer sport, with Capt Jacob recording a local record of 41 holes in one day.

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4 FD DENT COY NEWS

Officers Attend Dental Conference

Capt GIJ Bisaillon, Major C Brown and Lt Col Evans attended the 5th Annual USAREUR and USAFE Dental Conference held in Garmisch, Germany 19 - 20 May 61.

Duty Trip

Capt LE Kelly and Sgt JH Kay, Capt GT Crossman and Sgt JAR Shields recently spent a week in the Putlos area of Northern Germany on Battalion exercises.

Officers and Men No 4 Fd Dent Coy
Summer, 1961

4 Fd HQ Relocated

HQ 4 Fd Dent Coy was officially relocated at FT HENRY from FT CHAMBLY on 15 Apr 61. The new HQ consists of an orderly room, stores section, repair section, dental clinic and CO's office. The central casting laboratory remains as before in FT CHAMBLY.

Changes in Werl Area

The clinic and the laboratory at 1 Fd Amb FT ANNE was officially closed 15 Apr 61 and the space returned to the RCAMC. The laboratory has been moved to the clinic at FT ST LOUIS. We have one clinic only operating in the Werl area.

Party for Departing Families

On the evening of 6 Jun 61 the dental sub-section at FT CHAMBLY were hosts to an all ranks and their wives party to say farewell to those RCDC people returning to Canada this summer; Capt and Mrs Bisaillon, Sgt and Mrs Toole, Sgt and Mrs Shields and Sgt and Mrs Palmer.

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35 FD DENT UNIT NEWS

Officers Attend Conference

Lt Col GR Covey, Majors EMC Franklin, WH Harrington, and CJ Sivell and Capt JG Boucher attended the USAREUR/USAFE Dental Conference in Garmisch Germany on 19 - 20 May. One of the highlights of the conference was a movie on external massage - a graphic picture of a recent article in the Quarterly. Other subjects included Management of Facial Trauma and Management of Severe Facial Injuries.

Front Row - L to R - Major C Brown; Lt Col GC Evans; Col Charles M Farber, Chief Dental Surgeon, USAREUR HQ, Heidelberg, Germany; Lt Col GR Covey; Col R Johnson, Chief Dental Surgeon, USAFE HQ, Weisbaden, Germany.

Back Row - L to R - Capt GIJ Bisaillon; Major CJ Sivell; Major WH Harrington; Capt JG Boucher; Major EMC Franklin.

Major Hinch Celebrates Crowns

Maj Hinch, after many weeks of waiting, was at last able to "don his crowns" and offer the customary refreshments to friends and colleagues. This was done 17 May 61, under the erroneous impression (due to signal transmission error) that this was the official date of his promotion. An exchange of signals between AHQ and the unit soon established the fact that the correct date of promotion was 16 May, as reported in the last issue of the Quarterly. Regardless of date, however, the bar was crowded with celebrants at noon on 17 May 61 and a most enjoyable evening was spent in the Social Centre, by the "Dentals" and their wives.

Sgt Roberts and Cpl Parker Holiday on Riviera

Sgt JM Roberts and Cpl WJ Parker reported a happy holiday on the French Riviera in late May and early June, with their families. No real difficulties were encountered (at least none were admitted), in their first venture "under canvas". Both are sporting a deep tan which should last for some time to come.

LAW Fisher to England on Leave

LAW D Fisher spent an enjoyable leave in England during May and June, with evidence, in the form of an excellent tan, of an unusually sunny period during her holiday.

Passport Problems - Ssgt Lawson

Ssgt L Lawson and family visited Spain during April, although the Spanish authorities would not allow him to enter the country without a passport. This made it necessary to proceed to the Canadian Embassy in Paris for a temporary passport, followed by a quick run to Spain before his leave expired.

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The ROYAL CANADIAN DENTAL CORPS Quarterly

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Editorial Board: Col GB Shillington
Maj DH Protheroe
Lt Col GR Covey

SUBSCRIPTION RATES

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Cover Photo - HQ No 13 Dental Coy RCDC(R) - Sep 61

Bottom to Top - Left to Right: Col Leman, WO 2 Mulholland, WO 2 McLeod, S sgt Everett, Sgt Lunnin, Cpl Schmelzle, Cpl Eady, Capt Hunter, Lt Tullis, S sgt Weir, Cpl Wylie, Mr Brampton, Cpl Kennedy

EDITORIAL

THE RCDC STORES LIST

Most Corps personnel seem to agree that the RCDC Stores List, which contains approximately 1500 items, is a comprehensive selection of dental stores adequate to meet the normal treatment requirement of the Corps. Further, the Stores List is kept up to date by the addition and substitution of new items.

The Standing Stores Committee which is comprised of the DDGDS as Chairman; with the Commandant and Chief Instructor of The RCDC School and the Senior Procurement Officer as members; and a secretary, has the responsibility for advising the Director General concerning additions to and deletions from the Stores List.

In order that the Committee may discharge this responsibility efficiently and avoid waste of public funds a routine has been established for evaluating new equipment and supplies. When a member of the Corps suggests a new item or an article appears on the market which has possible application to the RCDC, it is purchased, assigned a project number and forwarded to The RCDC School and selected clinics for testing and evaluation, a process which may involve from three months to a year. When testing is completed, a full report is forwarded to the Committee which advises on procurement action.

In addition to practising economy in the use of dental materials, it is a responsibility of both dental officers and tradesmen to observe and assess the usefulness of materials currently used and also to suggest potentially useful new items. Only in this manner can the Standing Stores Committee maintain an up-to-date and comprehensive Stores List.

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CORPS PERSONNEL

As of 1 Nov 61 there were 504 military personnel employed in the Corps as follows: 155 regular dental officers; 1 dental officer call-out; 22 non-dental officers; 278 men; and 48 airwomen. Civilian personnel numbered 81 including: 8 Dental Surgeons (Part V); 10 Dental Surgeons (per diem); 46 dental nurses; and 17 other civilians.

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NO 13 DENTAL COMPANY RCDC(R)

Colonel A.C. Leman, CD, DDS

At the conclusion of the Second World War plans were made for the establishment of the first Canadian peacetime Dental Corps, comprised of active and reserve components. On October the 1st 1946, the date on which the Canadian Army was reorganized, 13 Dental Company came into being as one of the three original active force dental companies. In keeping with our tri-service function, 13 Company was designated as the "Air Force" company with its headquarters located at Central Air Command HQ, RCAF Station Trenton. The new unit, under command of Lt Col R.E. Carroll, had a total strength of 47 all ranks comprised of 11 dental officers and 36 WOs, NCOs and men and was responsible for the dental treatment of the personnel of the RCN, Army and RCAF located within the geographical limits of the Army's Central Command which now is designated as the province of Ontario.

Under the successive distinguished command of Lt Col R.E. Carroll, Lt Col F.R. Drewry, Lt Col H.L. Harris, Col K.M. Baird, Lt Col W.M. Sinclair and Col J.A. MacGowan, 13 Company developed in growth and status commensurate with increasing and ever-demanding service and treatment responsibilities until to-day the affairs and operations of this unit are performed by a service personnel staff of 32 officers and 51 WOs, NCOs and men plus 3 Part V Dental Surgeons, 5 Per Diem Dental Surgeons, 15 Part V Nurses and 8 Airwomen Dental Assistants. It is noted with pleasure that the eight "civilian" dentists who share our work-load, on full or part-time clinical duties, are all former officers of the RCDC viz, Brig E.M. Wansbrough, Cols C.B.H. Climo, F.R. Drewry, W.E. Meldrum, J.A. MacGowan, Lt Col C.W. McCrary, Majors W.O. Gardiner and J.C. Duff.

There are no isolated or even semi-isolated postings in 13 Company. The 26 clinics, of which 4 are part time, are located for the most part at military installations in the southern part of the province. Clinic accommodation within the command varies in size and construction from a one chair war-time construction building to the modern 5 chair standard RCDC clinic complete with chrome cobalt laboratory at Trenton. In lieu of specifically designed permanent clinics, two of our RCAF clinics are accommodated in several rooms on the ground floor of newly-constructed barrack blocks; in both cases the MIR is located in the same complex and is adjacent. A clinic of this type requires the minimum of alteration and is a great improvement over those in temporary buildings. No 7 Clinic in the Canadian Forces Hospital Kingston is one of the show places of 13 Company. Ultra modern in design and appointment in conformity with the hospital proper, the clinic is situated on the ground floor at the extreme end of one wing, with a private entrance to the grounds for out-patients from other units. The clinic consists of three separate operating rooms, DT Clinical bay, laboratory, dark room, store room, two offices, three wash rooms and a rather luxurious waiting room. As CFH Kingston is now recognized as a teaching hospital, our dental staff have benefited and contributed greatly by the close association that is maintained between the "meds" and the "dents" at this institution.

One of the greatest concentrations of 13 Company personnel is in the Ottawa area. Four full-time clinics are maintained at NDHQ, RCAF Station Uplands, RCAF Station Rockcliffe and HMCS Gloucester. In the near future a clinic will also be opened at the new National Defence Medical Centre. Another main centre is Kingston where 3 full-time clinics are maintained; No 13 at Eastern Ontario Area HQ (Canadian Army Staff College and National Defence

College), No 4 at Royal Military College and No 7 at the Canadian Forces Hospital Kingston. The remaining clinics of the company are located at various Army HQs and units and Air Force stations of Transport, Training, Materiel and Defence Commands in Ontario. In former years Camp Borden was the responsibility of 13 Company, however, with the location of The RCDC School at that site and the establishment of a Treatment Wing, the School has now taken over the treatment commitment for the Borden Area and administers No 23 Clinic at RCAF Station Camp Borden and the Part-time clinic at RCAF Station Edgar. The HQ of 13 Company is located at Air Transport Command HQ, RCAF Station Trenton. Although some inconvenience is experienced from time to time due to the location of HQ Central Command in Oakville, 125 miles to the west, there are many advantages to be gained in our present location. The spacious quarters that have been provided for us, in a separate building on the station, adequately accommodate the Administrative, QM Stores and Dental Equipment Sections under one roof. Flanked by the small cities of Trenton and Belleville on the Bay of Quinte the station is served by the trans-Ontario dual lane 401 highway, the mainline railway between Toronto, Ottawa and Montreal and of course the increasingly busy air terminal of Air Transport Command which is rapidly becoming the cross roads of the armed forces who concentrate here enroute to CBUME, the Congo, the Arctic and various parts of Canada. With the acquisition of 12 CC 106s, a long-range turbo prop cargo-troop carrier aircraft christened "The Yukon", Transport Command will soon begin flying service personnel and their dependents from Trenton to the Brigade in Germany and the Air Division in France. These aircraft, the largest ever built in Canada, can seat up to 167 passengers and are able to fly non-stop from Trenton to 1 Fighter Wing France in approximately ten hours.

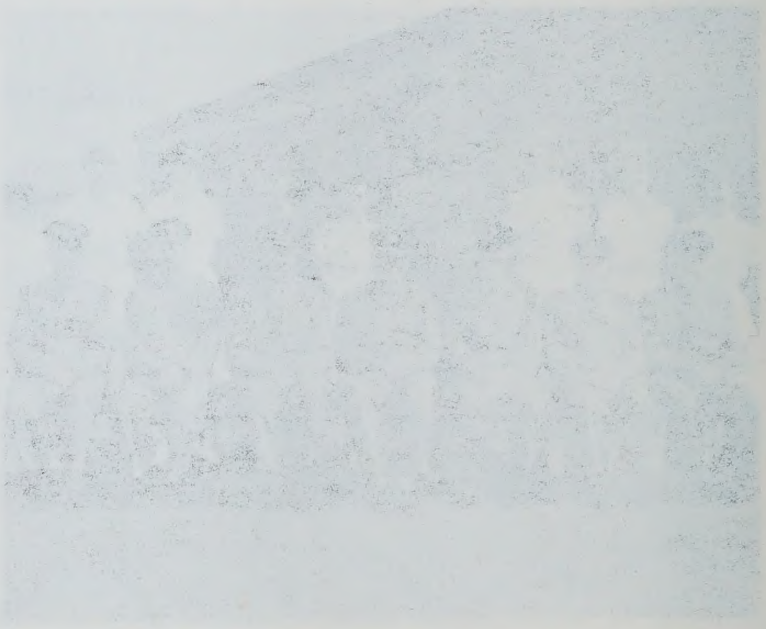
No 15 Clinic, RCAF Stn Trenton

Front Row - L to R: Sgt Vout, WO2 Riddell, Capt Gazo, Lt Col Cunningham, Maj Andrews, Capt Lincoln and Sgt Gilbert

Back Row - L to R: F/S Savage, AW1 Reddy, Cpl Palmer, Pte Stenabaugh, Mrs Darling, Sgt Raymond, Cpl Brennan, AW1 Carroll and LAW Hughes.

Other than deep sea fishing and mountain climbing the fulfilment of practically any aspiration one may have in the way of life can be found, if not at, then within a couple of hours of a posting in 13 Company. Those who are fortunate enough to be chosen for a tour of duty with this unit can look forward to a very full life under near ideal conditions. This naturally includes an honest day's work.

★★★★★★★★★★★



DENTAL SERVICES FOR THE CANADIAN FORCES

Brigadier K.M. Baird, OBE, CD, DDS, QHDS

Last April in Toronto, the Royal College of Dental Surgeons of Ontario convened a workshop which devoted a full day to the question of what additional procedures, if any, should dental auxiliary personnel be permitted to carry out under the direct supervision of a dentist and in accordance with the resolution adopted by the Council on Dental Education at the meeting of the CDA in Sept 1960. This workshop was attended by upwards of 170 dentists many of whom were representing organized dentistry throughout the province but many of whom were private dentists sufficiently interested in the subject to take the necessary time to attend. It was but another manifestation of the general concern of the profession as a whole in the persistent problem of the shortage of trained dental personnel and the provision of a more adequate dental service for the population. It was evident from the reaction at this meeting that there are some in the profession who believe that no real shortage of trained personnel exists and that the question is merely one of distribution. There are others who submit that the principal source of difficulty has a socio-economic basis and that all people who can afford treatment and are desirous of obtaining it are being cared for satisfactorily. However, there appears to be no doubt that the large majority of responsible members of the profession support the view that an acute shortage does exist; that a considerable proportion of the population is not receiving adequate dental treatment and that there should be action taken now by the profession to improve the situation and to preclude undesirable action by bodies outside the profession.

Many of the provinces have been actively investigating the problem of providing adequate manpower for the profession but in this regard Ontario is probably in the most favourable position of any at the present time. It is one of the two most fortunate provinces in overall distribution of dentists in rural and urban areas and it has had in being, up until this fall, the only training program for dental assistants and dental hygienists. The more widely dispersed population in the other provinces and particularly those in the West, presents a situation which is more acute and more difficult to resolve. In these provinces, determined and vigorous action has been necessary in order to avert an almost disastrous situation and the results have not always been the most desirable. The threat of intervention by outside sources has brought home the urgency of immediate and effective measures very forcibly indeed.

The considerations involved in providing a dental service for the Canadian Forces are very similar to those now facing the civilian profession with a few major differences. Distribution of dental personnel is more readily controlled in the RCDC and theoretically at least this should simplify the situation. However, where a shortage of such personnel exists - and it does in the RCDC, distribution is merely a stop-gap and not the final answer. Furthermore, the advantages of controlled distribution are more than offset by the other implications involved in dealing with Service patients. These patients have no financial responsibility for the treatment and they are, in a large measure, at the young adult stage where treatment required is the most time-consuming. The Survey of Dentistry in the United States recently published by the American Council on Education points out that the average dentist can care for about 1000 patients and that only a little over 40 percent of the population visits a dentist every year and receives, in some cases, minimal dental care. An additional 30 percent receives some care and the remainder virtually no care at all except for the relief of pain. Under these circumstances the existing number of dentists in the US are barely coping with the

demand for treatment but if the demand became anywhere near universal the situation would hopeless. These figures are fairly well substantiated when applied to Canada and are borne out by the Survey of Dental Practice 1953 as conducted by the CDA. Canadian dentists serve about 1000 patients each, with about 34% of the population being cared for regularly. In the Forces the ratio of dental officers to patients is at present about 1:950 and while the demand may not be universal it is certainly almost so - at any rate, a great deal higher than in civilian practice where the economic factor serves as a partial deterrent.

The ultimate aim of the RCDC under ideal circumstances is, of course, to establish the highest standard of dental health for all members of the Forces. This we appreciate is not realistic under existing conditions and so our current aim is to treat as early as possible all Category I patients in order to prevent or relieve pain and infection and to ensure that the minimum time from duty is lost as a result of dental disability. Having accomplished this, treatment can then be planned for the Category II patients on the basis of need and of demand and the maximum number of personnel then maintained in Category III. The existence of a considerable backlog of treatment and the necessity for employing every available means to assist in overcoming this undesirable situation is recognized in the RCDC. An overall programme consisting of five principal approaches has been established as a means of diminishing at least some of the undesirable effects of the situation. It is not expected that any one of these approaches by itself will make a profound impression on the question but collectively they may well prove to be a fairly positive contribution.

The first approach is being made towards improving the dental officer strength of the Corps by means of both an increased intake and an increased retention on a career basis. Two plans for the subsidization of dental undergraduates by the Dept of National Defence have been in effect for some years past. These plans have produced a reasonable annual intake from the universities but releases through normal retirement and at the termination of the required period of service have neutralized any gains in this direction. A revised Dental Officers Subsidization Plan has recently been adopted, replacing the two previous plans and offering terms which should provide a more satisfactory yearly intake. In addition, the dental officers allowance which was revised and increased during the past year and the improved rates of pay for the Services generally should reflect a more attractive outlook for the young officer who would like to consider a career in the Corps. It is not considered likely nor even desirable that all dental officer vacancies should be filled in the immediate future but a steady annual gain will ultimately provide well-motivated officers in the numbers required to meet the commitment. This programme has in the past, and should continue in the future, to benefit the civilian population as well, since a good proportion of the subsidized officers are released and available to civilian practice after completion of their required tour of duty.

The second approach to the question is through the avenue of dental health education. This is a continuous and systematic programme with a six-week period set aside each year during which dental health education is stressed throughout the Forces. The results from such an effort are long-term and may not be readily apparent but there are certain objectives which it is felt can be accomplished through educational methods. The aim is to impress on the serviceman and his dependents the need for and the value of the measures they themselves can carry out to improve their dental health. This is attempted through the media of lectures, slides and films and by the distribution of posters and literature and by the examination of children in the DND Schools. The programme is now in its third year and while the results are not impressive as yet, the reaction is sufficiently encouraging to warrant continuation of the effort.

The third approach that is being investigated is in the field of preventive dentistry. It is now generally accepted that the topical application of sodium fluoride is an effective anticariogenic agent in children and that indications are that stannous fluoride is even more effective. Stannous fluoride in addition shows promise as a preventive measure in adults. Preliminary results of a clinical investigation being conducted on young adults by the RCDC were published in the Jan 61 issue of The Quarterly. Should the final and complete data bear out the present findings, it is intended to adopt this procedure as routine for all recruits and for other personnel in the age group where the principal menace is dental caries. A significant reduction in the incidence of this disease for this particular group would form a substantial contribution towards resolving the problem and presenting it in more practicable proportions.

The fourth approach is through the provision and use of improved technical dental supplies and equipment and the adoption of the most efficient procedures available for our purpose. The Standing Stores Committee is constantly reviewing and investigating new items for possible inclusion in the stores catalogue. Similarly, The RCDC School is constantly investigating and developing improved procedures and techniques to form the basis of the refresher courses presented to both officers and auxiliary personnel. During the past year, as an example, the program of equipping the Corps with the air-driven turbine was completed. An evaluation of the effect of this programme was published in the Oct 60 issue of The Quarterly and has proven to our own satisfaction that this measure should assist materially in reducing the magnitude of our commitment. Combined with these improvements in equipment and techniques but above either of them there is, of course, the motivation of our personnel and the esprit de Corps involved in providing a health service of a standard in keeping with our position throughout the Forces. The rate of achievement for the Corps generally, rose from 53.3 in 1952-53 to 66.4 in 1960-61 and this fact alone exemplifies the goodwill with which our service is given.

The fifth and final approach to be mentioned is through the employment of our dental auxiliary personnel. The RCDC is now carrying out a pilot study on the training and employment of the dental technician clinical in certain technical oral procedures which it is considered can be safely delegated and supervised by the dental officer. Should the results of this study disclose that such auxiliary personnel can be trained economically to the desired standard and employed effectively in RCDC clinics then it is intended to expand the duties of these clinical assistants by the inclusion of certain of the routine procedures normally carried out at the chair by the dental officer. The clinical technicians in their present role, have proven themselves to be most valuable contributors to our dental service and accordingly their numbers have been increased from the original six to the present establishment of 22. It is just possible that with further training and expanded responsibilities they can be of even greater value in the Corps.

Each of our five approaches has, of course, a counterpart in the civilian profession. However, in the RCDC there is a more direct control of the programme and the results should be more readily apparent. The effectiveness of our methods will, in the final analysis be proven or otherwise by time alone but for the present our aim is to ensure that every possible effort is being made towards meeting the challenge.

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ANTERIOR BRIDGES - FULL OR PARTIAL COVERAGE?

Major P.L. Falkner, CD, DDS

It is not the intention of this article to present new or earth-shaking material, but simply to review the salient factors that should be considered in the choice of retainers for anterior bridges. The trend is more and more to the use of complete veneer crowns with the partial veneer or 3/4 crown reserved for more or less ideal cases. This situation has arisen because the veneer type of retainer has proven to be the most reliable method of attachment, however, depending on the indications of the case, a pin-ledge or dowel crown retainer may be employed.

The veneer crown is a surface covering of a part or all of the crown. In a partial veneer crown, only the functioning surfaces of the tooth are covered. A complete veneer crown, as the name implies, covers the entire coronal portion of the tooth and in both cases, retention is developed between the inner surfaces of the casting and the external walls of the prepared tooth.

Among the many factors which govern the choice of retainers in the anterior region of the mouth, that of esthetics is of prime importance. To avoid a "mouthful of gold" appearance, it is necessary to show as little gold as possible. This can be accomplished with little difficulty when using a 3/4 gold crown on a correctly aligned tooth where the mesial and distal alices and occlusal reduction, when properly executed, will result in a minimum of gold showing. However, the placement of a 3/4 gold crown on a tipped or rotated tooth may require overcutting to such an extent that the metal display is excessive.

In the case of a complete veneer or full crown, there must be a modifiction to meet the esthetic requirements. This is usually accomplished by the insertion of an acrylic or porcelain labial facing in the crown. Often the final shade of these facings leave much to be desired and there is a need for more space to accommodate the acrylic or porcelain which involves a greater reduction of the tooth.

This brings up the point of conservation of tooth structure. An attachment should be selected which can be placed upon the abutment tooth with the least amount of cutting consistent with good retentive qualities. When a tooth is free from caries or other enamel defects, a partial veneer crown is ideal, indeed, conservation of tooth structure is its chief advantage. In teeth marred by extensive caries, discolouration, erosion, or abrasion a complete veneer crown is indicated. Extensive caries activity produces a slow but progressive resorption of the pulp and a consequent thickening of the dentine layer, making an unfavourable response to additional cutting less likely.

Gaining maximum retention is a factor no less important than esthetics. Retention is obtained in the partial veneer crown by retentive grooves, near to paralled proximal walls, a correctly reduced cingulum, and auxiliary retention points as required. In the complete veneer crown, the frictional fit makes it the most retentive of all attachments and it should be used on teeth with naturally short crowns, or on badly abraded teeth where the clinical crown has been reduced.

The arch form is significant in anterior bridgework. The greater the curvature of the anterior segment of the arch, the greater the leverage exerted on the restoration. In a bilateral anterior bridge, such as a cuspid-to-cuspid

span, the body of the bridge invariably deviates from the straight line, curving labially from one abutment to the other. The distance between the centre of the curved labial and a straight line drawn between two cuspids is the length of the lever arm. This multiplied by the force applied to the incisal edge gives the magnitude of the tipping factor present in the restoration. A full crown is more likely to resist distortion and displacement under such a force.

The oral hygiene of the patient has a bearing on the choice between a partial or complete veneer crown. The use of a partial veneer crown is contra-indicated for teeth with soft, chalky, poorly calcified enamel which does not provide a suitable wall against which to finish the margins of a casting; or when extensive caries will necessitate the removal of large amounts of tooth structure. Full coverage, on the other hand, provides protection against secondary decay since the whole crown is covered and the margins are placed beneath the gingival margins.

Summary

Partial or complete veneer crowns are used in 90% of anterior bridges. The partial veneer crown is limited in use. Its main advantages are maintenance of esthetic harmony and conservation of tooth structures, but the retentive and resistance qualities are not as good as in the complete veneer crown. The complete veneer crown provides the best retention, gives greater protection against secondary decay, and can be used to cover hypoplastic, stained, eroded, abraded, malposed, rotated or badly decayed teeth. However, its preparation requires a greater reduction of tooth structure and the gold must be covered by a porcelain or acrylic veneer. Its use is contra-indicated on young teeth with large pulps.

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2. J.A.D.A. Vol 26, Feb 61, Cowger - Retention, Resistance and Esthetics of the Anterior 3/4 Crown
3. Ginn J: Review of Dentistry
4. Lectures given at The RCDC School by Lt Col J.W. Turner, DDS

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TEMPORARY PROTECTION OF PREPARED ABUTMENT TEETH

Major A.G. Taylor, DDS

During construction of a bridge some form of temporary protection must be used to shield prepared abutment teeth against pulp irritation, damage to margins, extrusion and lateral movement.(1) In order to make cementation of the finished bridge easier, it is also desirable to prevent tissue overlapping the gingival margins of the preparations.

Types of Protection

There are many types of temporary coverage currently in use such as aluminum shell crowns, contoured copper bands, celluloid crowns, resin crowns, low fusing metal, cement or silicate crowns and acrylic splints, which may be sealed with a variety of substances including: zinc oxide and eugenol, gutta percha; and temporary cements.

Requirements of a Good Protector

1. Keeps prepared teeth free from contact with saliva and food debris.

2. Prevents damage to preparations.

3. Prevents extrusion and lateral movement of abutment teeth.

4. Protects teeth against pulp irritation.

5. Is not time-consuming in construction.

6. Is inexpensive.

7. Can be removed and recemented several times without destruction.

8. Gives a good esthetic effect.

Advantages of Acrylic Splints

All of the above requirements of good temporary protection for abutment teeth are adequately met by a well-constructed acrylic splint.

1. Acrylic splints can be sealed with a temporary cement to prevent the entrance of saliva and food debris.

2. Strength is one of the greatest advantages of the acrylic splint. Being much stronger than other types of temporary protection, acrylic splints have been known to keep the pulp and preparation unharmed for as long as three months when final treatment was delayed.(2)

3. The acrylic splint can be trimmed to restore occlusion thereby preventing extrusion of the abutment teeth. Contacts may be incorporated into the splint which, when coupled with the splint's bracing action, prevents lateral movement.

4. Being low in thermal conductivity this type of protection prevents pulp irritation.

5. The procedure used in construction of the acrylic splint is not overly time-consuming as it can be completed and inserted during the first appointment. Time is actually saved in the end since one splint will last as long as it is required, while with other types of protection, a remake is often necessary.

6. The acrylic splint is relatively inexpensive since a dozen splints can be made from one bottle of powder and one bottle of liquid.

7. If, when dislodging the splint with an instrument, a reasonable amount of care is taken, damage to the gingival margins can be avoided. The splint can be removed and recemented as often as required.

8. It is possible to achieve excellent esthetics. At times the esthetic effect of the temporary splint will be superior to that of the final or permanent restoration. To prevent this unfavourable comparison some dentists advocate the selection of a very dark shade of acrylic.

Construction of the Acrylic Splint

At the commencement of the first appointment a full alginate impression is taken over the unprepared teeth. The impression is poured and the cast allowed to harden. While the dentist is preparing the abutment teeth, the laboratory technician fills in the space on the stone model with plastic teeth which are waxed into position to form the corrected model. An alginate impression is taken of the corrected model and placed in a humidor.

When the preparations are "roughed out" in the mouth, the alginate impression of the corrected model is dried off and the bridge area of the impression is filled with self-curing acrylic of the proper shade and seated in the mouth.[3] When the acrylic has set sufficiently to be removed in one piece from the mouth it is placed in hot water to hasten the set. The splint may then be trimmed, and the occlusion adjusted and after polishing, it is inserted with zinc oxide and eugenol temporary cement.

Suggested Aids

1. To accelerate the setting of the acrylic, have the patient rinse his mouth with warm water just prior to insertion of the alginate impression. Also rinse the impression itself with warm water.

2. The gingival margin area of these splints is most often inadequately covered because of the thinness of the acrylic material at this point. By taking a #11 Bard-Parker blade and cutting a little of the gingival margin away in the alginate impression prior to insertion of the acrylic material, the additional space created will provide more bulk in the finished acrylic splint. The same result may be obtained by adding a little inlay wax to the cervical 1/3 of the abutment teeth on the corrected stone model.

3. It is not necessary to finish the fine detail of the abutment preparation at the first appointment. The shoulders of the "roughed out" preparations may be finished at the next appointment.

4. It is not necessary to duplicate flaws of the original abutment teeth in the splint as these can be eliminated by grinding or adding inlay wax on the corrected model.

5. The application of a little vaseline on the gingival tissue in the bridge area will offer protection against irritation by the acrylic monomer.

6. Tylman[2] describes a technique using rubber base impression material in place of alginate which may produce a superior splint in the hands of some dentists.

7. If it is anticipated that the splint will be worn for an unusually lengthy period it may be reinforced with copper bands as described by Ewing.(4)

Summary

The reasons for using temporary protection of prepared abutment teeth are outlined and the types of protection currently in use listed. Eight requirements for a good temporary protector are suggested and the acrylic splint described which adequately meets these requirements. A technique for the construction of an acrylic splint is discussed as well as some suggested aids for obtaining an improved result.

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1. Johnston, J.F. Modern Practice in Crown and Bridge Prosthodontics. Saunders, 1960, Chap. V, P.52.

2. Tylman, S.D. Theory and Practice of Crown and Bridge Prosthesis. 3rd ed. Mosby, 1954, Chap. XXIII, P. 323.

3. Freeze, A.S. Impression for Temporary Acrylic Resin Jacket Crowns. J. Pros.Dent. 7:99 Jan 1957.

4. Ewing, J.E. Fixed Partial Prosthesis. 2nd ed. Lea and Febiger, 1959, Chap. XVIII, P. 166.

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FROM THE REPAIR DEPARTMENT

S sgt EMB Everett

Dentistry, like most modern sciences is continuously advancing. Gone are the days of limited equipment, foot-operated engines and amalgams pushed in with the thumb. New research, new methods of treatment and new techniques have added to the professional skill and ability of the dentist. In keeping with these advances it has been necessary to design and develop new and complicated equipment, capable of high speed, adaptability and performance in conjunction with the serviceability required for almost constant operation and, as a result, the dental equipment repairman has become as essential to the dental team as the dental assistant and the laboratory technician. It is only necessary to consider the modern dental clinic equipped with all the new aids, motor-operated foam-padded chair, X-ray Unit, and completely equipped operating unit in order to realize the importance of the equipment repairer to the dental team. Much of the equipment is self-contained with electrical and air-operated instruments, lights, dials, switches, buttons, valves or other controls, reminiscent of space-age robots.

The dentist has mastered the switches, buttons, controls and the technique needed to operate this special equipment but when a breakdown occurs he relies on the dental equipment repairman to trace and repair the breakdown as quickly as possible. Repairs to these complicated machines are time-consuming and costly in loss of time to the dentist, the patient and the Corps. No longer can the dentist call in the local plumber or handy-man. His new equipment is specially designed to work at high speed and is manufactured from different components, metal and otherwise. Underneath the bright and attractive covering

is a maze of wires, tubes, relays, switches, valves, fuses and other strange-looking devices. All parts are machined to very close tolerances to permit smooth working at high speed and because of the high speed required, many component parts tire quickly and break down. Picture one part of an air turbine where a few tiny metal spheres smaller than the periods used in this article, are required to turn a bur at speeds of 300,000 RPM and remain vibration free. When it is considered that only good cleaning and proper oiling are required to keep them rolling, the importance of routine maintenance is apparent.

Part 6 of the Manual of Dental Services outlines the maintenance of most Corps equipment and it is the responsibility of those concerned to acquaint themselves thoroughly with these procedures. A word of caution, however, is necessary. If a piece of equipment has been properly kept, cleaned and oiled as required, yet fails to work, only those minor adjustments authorized at clinic or laboratory level should be carried out. If this fails to get the piece or part back to normal working efficiency, DO NOT ATTEMPT TO REPAIR IT. Call the equipment repair department or ship the defective equipment to Coy HQ. Attempts by unqualified personnel to repair equipment have often caused additional damage and, in many instances, put the parts or pieces beyond repair even by the repair department.

The RCDC must have equipment available for the field, for ships at sea and for clinics in Canada and abroad. Wherever the Canadian serviceman goes, he depends on the RCDC to meet his dental requirements. With planning and foresight in procurement, well-equipped dental repair departments and the cooperation of all members of the dental team, the Corps will be ready to meet all future needs.

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FACIAL ASYMMETRY

Captain JLY Cyrenne, DDS

There is no true symmetry of the face yet marked asymmetry is fairly uncommon. It may be due to the destruction of the growth centres in one or more of the facial bones and the mandible, which is the most vulnerable facial bone, is most often involved. The mandible has six growth centres, the most active of which is located at the head of the condyle. According to Engel and Brodie(1), "noxious influences such as endocine disturbances, middle ear infections, arthritis, hematogenous infections and other causes can affect the active cartilage centre at the head of the condyle". Traumatic injuries may occur during birth through the use of obstetrical forceps or may result from blows on the chin during infancy or childhood. Such injuries can also cause a disturbance of the condylar growth centre.

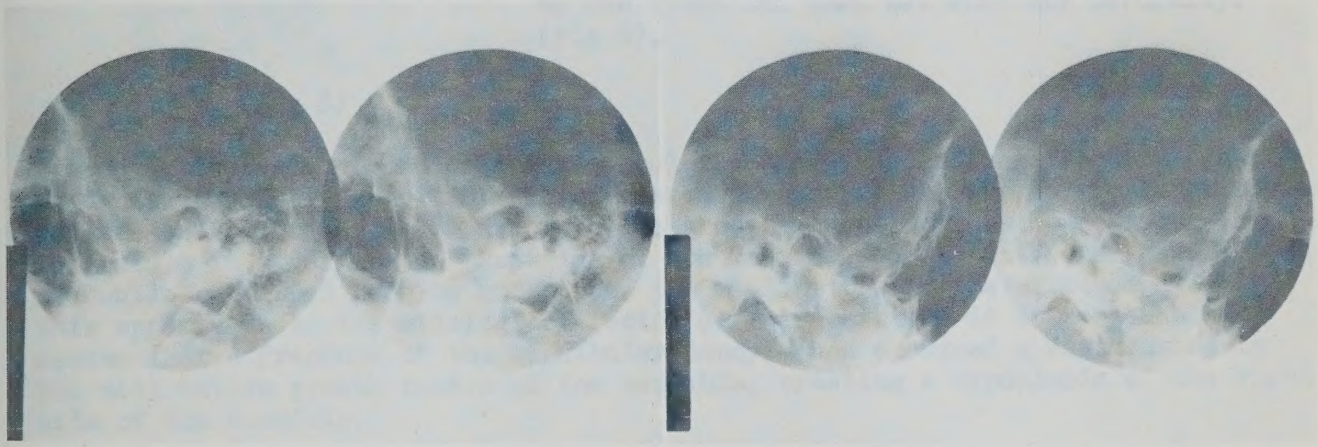
Case History

This 18 year old airman was admitted to hospital with a history of phimosis. The head and neck examination revealed a facial deformity that appeared to be either a hyperplasia of the left side of the mandible or a hypoplasia of the right side. (Fig 1).

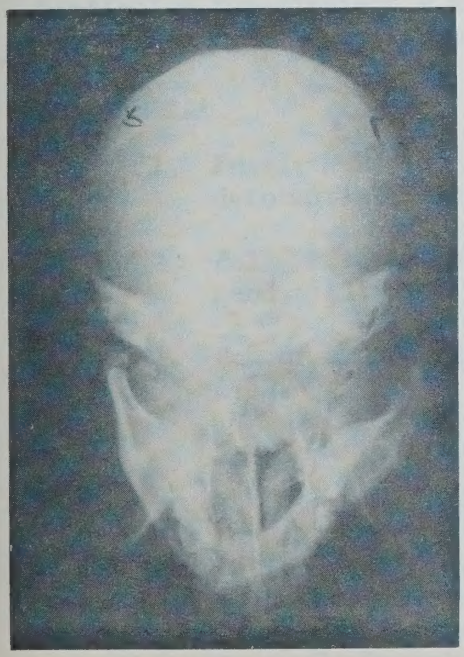
The past history indicated that the patient fell on his chin when he was about ten years old. Since no discomfort followed, his parents felt medical attention unnecessary, but in fact, the accident had produced a fracture of the right condyle causing an arrest in the development of the condylar growth centre on that side.

(Fig 1)

The x-ray report read as follows: "There is asymmetry of the mandible with loss of the normal anterior arching. The left T.M. joint is normal, and movement from the closed (Left Fig 2) to the open position (Right Fig 2) appears normal. The right T.M. joint shows a fractured condyle. (Fig 3). A fibrous union has taken place but the fragment presents an abnormal position, having moved forward and downward. In the closed (Left Fig 3) position the space between the head of the condyle and the bottom of the glenoid fossa is larger than on the left side. In the open position (Right Fig 3) the condyle appears to be subluxated. (Fig 4) shows a definite malposition of the right condyle and a distortion of the left body of the mandible. No other asymmetry of the facial bones is noted. Nothing unusual is noted about the skull. The bony texture is not unusual".



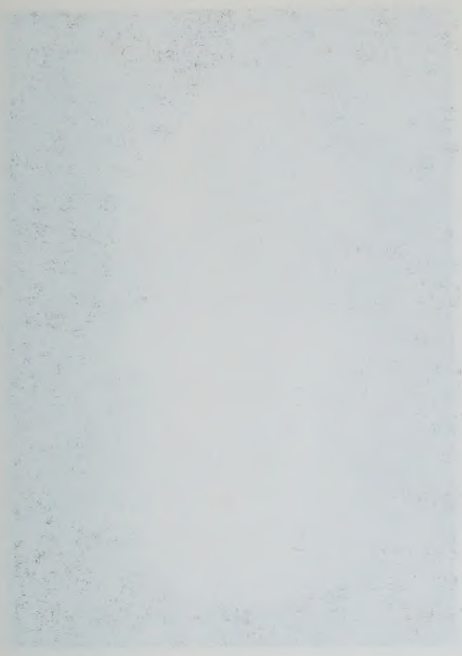
(Fig 2) (Left Side) (Fig 3) (Right Side)



(Right) (Fig 4) (Left)

The oral examination revealed a deviation of the midline of approximately 3mm toward the right side, narrow arches, crowding in the anterior region and inversion of the lower posterior teeth. An incisal fracture was observed on the upper left central and the patient confirmed that this was due to an accident in childhood. The occlusion was functional. The case was diagnosed as right mandibular hypoplasia.

No treatment was attempted in this case, because there was no discomfort or impairment in the function of the jaw. The patient's only complaint was esthetic in nature and since the growth centres of the mandible are active until at least the 20th year, it was not considered desirable to intervene at this time.



Discussion:

There is a great deal of variation in the etiology of facial asymmetry. The causes may be found in pre-natal as well as in post-natal life. Maintenance of abnormal posture during gestation has been shown by Holt and McIntosh(2) to interfere with the symmetrical development of the face. "Intrauterine pressure due to the so called 'position of comfort' assumed by the fetus frequently results in asymmetries of the face and jaws which may be permanent if severe enough, especially in children with osteogenic disturbances or deficiencies".

(Fig 5)

There was nothing in the present history to confirm such theories. It is likely that a congenital deformity will manifest itself in early life and, according to the history, the patient became aware of the deformity only when he joined the Armed Forces two years ago. It is also interesting to note that a picture of the patient when he was about ten does not show any deformity. (Fig 5).

Hyperplasia of one of the mandibular condyles is another frequent cause of facial asymmetry. In the case discussed however, there was no sign of condylar enlargement. "Traumatic injuries to the growing cartilage on the condylar head may result in a failure of that side of the mandible to elongate, the normal side meanwhile continues to grow and pushes the midline toward the affected side".(3) This appears to be the etiological factor in this case and it is reasonable to assume that a fracture of the mandibular condyle has produced a disturbance in the most active growth centre of the mandible, creating a hypoplasia of the right side of the mandible.

Summary:

A case of facial asymmetry has been observed and diagnosed as unilateral mandibular hypoplasia. A traumatic injury in childhood appears to have initiated the deformity. No treatment was rendered.

References:

1. Engel, M.B. and Brodie, A.G. Condylar growth and mandibular deformities. Surgery, 22: 976-992, 1947.

2. Holt, L.E. and McIntosh, R. Holt's diseases of infancy and childhood. 11th ed. New York, D. Appleton Century Co. 1939.

3. Schour and Massler. Atlas of the mouth. American Dental Association, 1952.

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Post-Graduate Training

During the past five years the Corps has provided 79 post-graduate courses for dental officers, not counting courses at The RCDC School. The distribution has been as follows: Oral Surgery 15; Crown and Bridge 7; Operative Dentistry 3; Advanced Dentistry 7; Periodontics 7; Radiology 3; Public Health 2; Pedodontics 1; Complete Dentures 13; Partial Dentures 6; Oral Diagnosis and Pathology 3; Endodontics 3; Mass Casualty Care 3; and miscellaneous 6.

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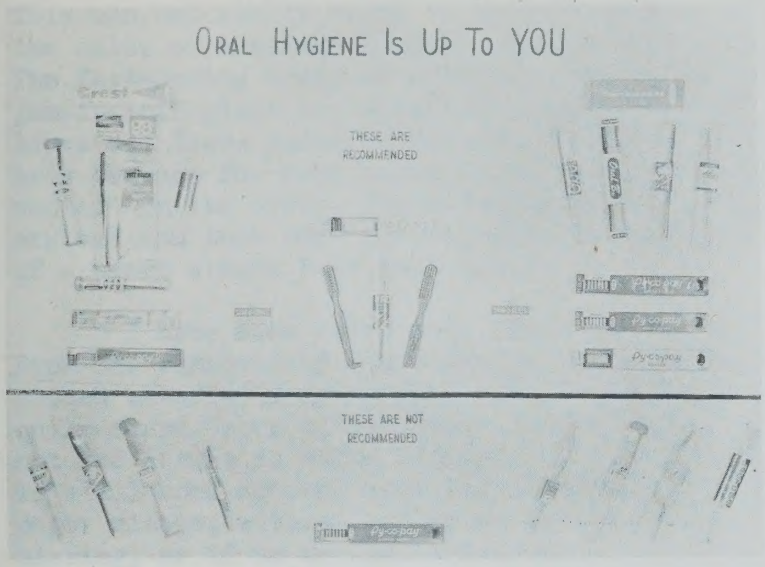
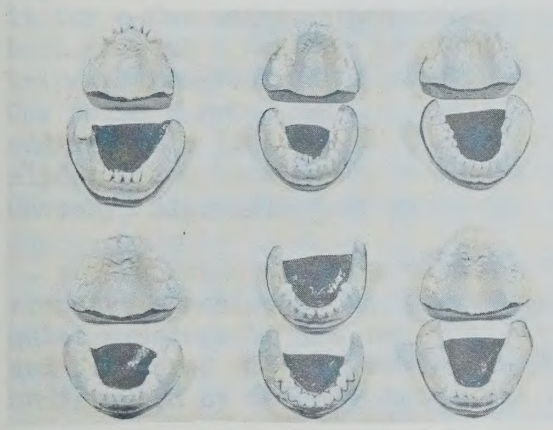
TRAINING AIDS FOR DENTAL TECHNICIANS CLINICAL

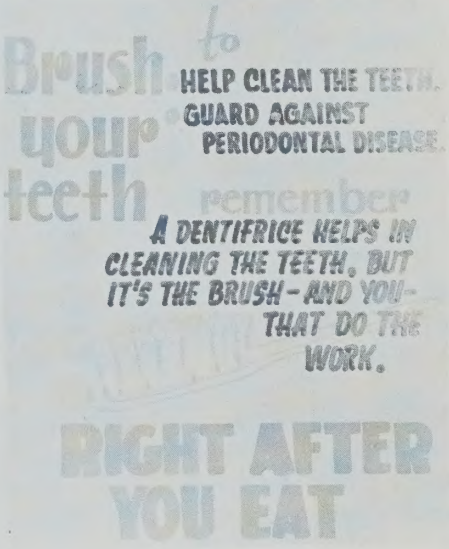
The following photographs illustrate some of the training aids prepared by S sgt JCA Therrien, DT Cl at No 1 Clinic, Ottawa to assist him in patient education.



This display of toothbrushes is made using a 30" x 36" sheet of 1/4" plywood. It includes toothbrushes for infants, children, adults, dentures, travelling and periodontal therapy, as well as other aids to mouth hygiene.



Models are obtained and painted appropriate colours to show malposed teeth, the results of thumb sucking, tooth decay, gross calculus periodontal pockets and a healthy mouth.



Poster

A variety of 35 mm slides and mounted radiographs are used to demonstrate calculus deposits, periodontal pockets, tooth decay, fillings, etc.

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UP THE MATTAGAMI

Cpl EPH Sprathoff

"A fine way to start a trip, with the train eight hours late", I remarked to the young reporter who interviewed us on arrival at Timmins. This was not really meant to be a facetious remark. Our adventure into the wilds of northern Ontario started with a train wreck and a messy one! The fast-moving train on which my wife and I were making the journey to our jumping-off place was derailed between North Bay and Porquis Junction. Believe me, I was grateful for the first aid training I had received in the Army because for four hours I was required to render first aid to the postmaster on the train, whose condition was very serious. The doctor finally arrived and took over but our efforts proved fruitless when the patient died of a heart attack four days later.

I have been asked many times why I spend my leaves in the bush far away from the comforts of civilization. Struggling through thickets, over rocks, around waterfalls or through swift rapids, always fighting blackflies, mosquitoes and other little pests, doesn't seem to be the way to enjoy a rest, but the answer is quite simple. If a person likes wild, open country (there is still some around) uncluttered by beverage bottles, garbage and discarded paper dishes, without having to listen to the sound of a half dozen radios blaring, or if he is inclined to be a fishing enthusiast, or even a camera bug after pictures of plants or animals, then he must do what I did - rough it for a few weeks. Surprisingly enough, most people who have been in the bush on such a holiday are eager to return the following year. While our trip was hazardous at the beginning, we considered it a success in every way. Our prime purpose, other than the holiday, was to take movies of this country and its wild life and we took 950 feet of 8 mm colour film, and numerous 35 mm slides which have added considerably to our film library of numerous jaunts in Germany, Algonquin Park and along the rugged Petawawa River.

We found exciting wildlife, breathtaking waterfalls and rapids, colourful scenery; experienced the physical hardship of paddling and portaging followed by quiet evenings by the campfire after a sumptuous meal cooked over an open fire and flavoured with woodsmoke. Night time found us fast asleep under the stars, undisturbed by the numerous night noises.

In the morning, after a dip in the river and a delicious breakfast of oatmeal, Danish bacon, coffee and pan-fried biscuits, we would load our equipment and supplies into the Voyageur canoe and resume our leisurely journey. A number of times we had to portage which is not an easy task with 650 pounds of baggage, rifles, fishing tackle and a 15-foot aluminum canoe.

One incident stands out above others in excitement. One section of the river was a swift rapid, too shallow to float the canoe with the two of us in it, and we were forced to literally walk, swim across pot-holes tugging the canoe, and continually fight for a foothold on this two-mile downstream stretch. It took us three and a half hours to navigate and even with the help of some rum, our feet and legs were blue and numb with cold. The highest water temperature was 52, while the highest air temperature was 71 in the shade.

Although it may be considered a rough way of life, canoeing and camping along the Mattagami River on the way to Moosonee is a most satisfying and enjoyable experience. To the fishermen in the Corps I would like to say that I never have experienced better fishing using ultra-light tackle. Getting your limit in twenty minutes can be considered good fishing anywhere. On this

occasion we caught mostly pickerel but there were a few pike of trophy size. As for game, I can only say that the so-called hunter's paradise is poor in comparison. There were moose, geese, ducks, ruff grouse, Hungarian partridge (there IS a difference) and wolves, to name a few. Bears were not in evidence during daylight hours but we heard them around the tent at night, even though we disposed of our garbage very carefully.

For provisions we took mostly high protein foods, lots of nuts, raisins, dried fruits, twenty-five pounds of flour, ten pounds of salt, ten pounds of sugar, eight pounds of tinned Danish bacon, sardines, smoked oysters for a treat, three pounds of shortening, six pounds of tinned butter, five pounds of oatmeal and, of course, the old standby bully beef, fifteen pounds of it. Some of the comforts of civilization are necessary. For those campers interested in eating well, the following is a good recipe:

2 tins of bully beef
3 lbs of potatoes
3 clove buds
2 bay leaves (medium)
¾ teaspoon black pepper
1 cup bacon grease
1 lb onions
salt to taste

While the potatoes are boiling, put the bacon grease in the frying pan and add the roughly diced onions allowing them to brown slightly. Then add the corned beef, cloves, broken bay leaves and the pepper and let fry very vigorously for ten minutes. Then simmer until the potatoes are done. Pour the water off the potatoes and mash (your ax handle will do), add the meat mixture and stir well. This will serve six but, considering the appetites of campers, two can polish it off quite easily.

A simple way to prepare fish is to remove the entrails but do not scale or cut off head or tail. Fill the belly cavity with two strips of bacon, then close it with three or four small wooden pegs. Salt the outside of the fish, wrap it tightly in strong foil and cover completely in the ashes of the fire. If you have no foil, clay will suffice. Cook thirty minutes for each hand-length and you will find that the skin will come off very easily and the meat will practically fall off the bones.

Our 15-foot Voyageur canoe proved itself beyond a doubt to be the best type for this sort of travel with its aluminum hull more resistant than the ordinary canvas covered type. After a run through rapids it resembled an old dented punt, but it never developed a leak and the dents and bumps were easily straightened out with the help of two pieces of wood.

From the beginning until the end of our trip up the Mattagami to Moosonee there was no such thing as "time", just the green and golden "now".

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RCDC Clinics

At present the Corps operates 81 full-time and 30 part-time clinics. These are comprised of: 32 one-chair clinics; 38 two-chair; 9 three-chair; 9 four-chair; 12 five-chair; 4 six-chair; 2 seven-chair; and 1 nine-chair clinic. In addition, The RCDC School has 22 chairs.

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PROMOTIONS

Congratulations are extended to the following personnel on their recent promotions:

Capt	JJN	Wright	-	to Major
Sgt	AJA	MacFarlane	-	to S sgt
Sgt	HEW	Reid	-	to A/S sgt
Cpl	JIJ	Boulanger	-	to A/Sgt
Cpl	HK	Drawe	-	to A/Sgt
Cpl	JG	Moore	-	to L/Sgt
Cpl	HH	Nogler	-	to L/Sgt

WELCOME

We welcome Capt Lee Reynolds back to the fold after a brief tour on civvy street, as well as Pte DL Kerr on transfer from the RCHA and Pte JM MacLean from the Guards. New airwomen DAs include AW2 DJ Lawrence at RCAF Station Camp Borden, LAW MBA Perusse, RCAF Station Namao and LAW MIE Cornut, RCAF Station Chatham.

RELEASES AND RETIREMENTS

Pte DG Hoffman, recently of No 1 Clinic, Ottawa, has retired after 21 years' service in the army, seven years of which were spent in the Corps as a dental storeman at No 1 Dent Eqpt Dep and No 1 Clinic. Pte Hoffman and his wife Rose plan to remain in Ottawa.

The following officers have entered private practice on completion of their tours of duty with the Corps:

Capt	O	Chaikin
Capt	WR	Black
Capt	RA	Bell
Capt	JGG	Hebert

POSTINGS

The following Corps personnel and Airwomen have been posted since the last issue of the Quarterly:

Major	ED	Fraser	-	to HMCS Stadacona Halifax from RCAF Stn St Hubert
Major	JI	Gordon	-	to RCAF Stn St Hubert from HMCS Stadacona
Major	AL	Kelland	-	to HQ Cencom Oakville from 35 Fd Dent Unit
Major	JA	Lauziere	-	to Ft Osborne Bks Winnipeg from HQ Camp Shilo
Major	SW	Muller	-	to 14 Coy RCAF Stn Winnipeg from Ft Osborne Bks Winnipeg
Major	GE	Windsor	-	to 7 PD London from 35 Fd Dent Unit
Capt	MA	Abramson	-	to HMCS Cornwallis from The RCDC School
Capt	FC	Arpin	-	to CBUME from HQ Ft Churchill
Capt	PJJ	Coulombe	-	to 4 Fd Dent Coy from RCAF Stn Clinton
Capt	GJB	Dionne	-	to RCAF Stn Comox from The RCDC School
Capt	R	Lanthier	-	to 1 Clinic AFHQ Ottawa from CBUME
Capt	RJ	Paturel	-	to Ft Churchill from Ft Osborne Bks
Capt	OA	Tucker	-	to RCAF Stn Winnipeg from Ft Osborne Bks

POSTINGS (cont'd)

S sgt	FR	Taylor	-	to Ft Osborne Bks from HQ Camp Shilo
S sgt	JCA	Therrien	-	to 1 Clinic AFHQ, Ottawa from RCAF Stn Clinton
Sgt	E	D'Avignon	-	to 15 Coy HQ from RCAF Stn Goose Bay
Sgt	HEG	Franzgrote	-	to RCAF Stn St Hubert from HQ NWHS Whitehorse
Sgt	FG	Grundy	-	to HMCS Stadacona from 35 Fd Dent Unit
Sgt	T	Hussey	-	to Goose Bay from HQ Quecom
Sgt	JF	Marchand	-	to 35 Fd Dent Unit from HMCS Stadacona
Sgt	JV	Minnelli	-	to 1 Clinic AFHQ, Ottawa from Camp Petawawa
Sgt	WD	MacDougall	-	to RCAF Stn Sea Island from Ft Churchill
Sgt	WS	Richardson	-	to RCAF Stn Camp Borden from The RCDC School
Sgt	VH	Shaw	-	to 4 Fd Dent Coy from RCAF Stn Comox BC
Sgt	RJJ	Tremblay	-	to Camp Petawawa from RCAF Stn Clinton
Cpl	JC	Bleakney	-	to HMC Dockyard, Halifax from Camp Gagetown
Cpl	PAP	Hughes	-	to HMCS Stadacona from Camp Gagetown
Cpl	RJ	Lowery	-	to The RCDC School from RCAF Stn Sea Island
Pte	C	Forsythe	-	to Quebec City from The RCDC School

Airwomen

F/Sgt	PE	Savage	-	to RCAF Stn Trenton from RCAF Stn St Jean
Cpl	JA	Brennan	-	to RCAF Stn Trenton from 35 Fd Dent Unit
Cpl	BJ	Leong-See	-	to RCAF Stn Comox from RCAF Stn Winnipeg
LAW	CMR	Barbor	-	to RCAF Stn Clinton from RCAF Stn Aylmer
AW1	PLM	Babish	-	to RCAF Stn Greenwood from RCAF Stn Goose Bay
AW1	JA	Bowes	-	to 35 Fd Dent Unit from RCAF Stn Trenton Ont
AWI	YML	Fournier	-	to RCAF Stn Winnipeg from RCAF Stn Rockcliffe
AW1	FR	Peck	-	to RCAF Stn Downsview from RCAF Stn St Jean
AW2	E	Allen	-	to RCAF Stn Bagotville from RCAF Stn St Jean

TRAINING

During the period since 1 Aug Corps personnel have participated in a variety of training as follows:

University of Toronto

Col	CE	Purdy	-	The RCDC School	- Occlusion and Occlusal Correction - 16-20 Oct

University of Oregon

Maj	MP	Quinn	-	11 Coy	- Oral Surgery - 23-26 Oct

Royal College of Surgeons, London, England

Capt	FW	Lovely	-	12 Coy)	- General Oral and Dental
Capt	JG	Boucher	-	35 Fd Dent Unit)	Surgery - 23 Oct - 15 Dec

Walter Reed Army Medical Center, Washington, DC

Maj	WR	Thompson	-	The RCDC School	- Advanced Dentistry - 26 Jul - 17 Nov 61

Doctors' Hospital, Toronto

Maj	JVP	Chatwin	-	13 Coy	- Oral Surgery - 6 Sep - 27 Oct

TRAINING (cont'd)

The RCDC School

University Undergraduates

A total of 26 subsidized officers and officer cadets completed summer training at The RCDC School in 1961. Fourteen undergraduates completed Phase 2 training and ten undergraduates and two graduates completed Phase 3. The following is a breakdown by Universities:

Dalhousie University	-	4
University of Montreal	-	5
University of Toronto	-	8
University of Manitoba	-	1
University of Alberta	-	8

The following cadet awards were made:

Honour Cadet	-	O/Cdt WE Russell	- Dalhousie University
Chief Instructors Trophy (Clinical Proficiency)	-	2/Lt GA Johnston	- University of Toronto
Field Exercise Trophy	-	O/Cdt WE Russell	- Dalhousie University
	-	O/Cdt NH Andrews	- Dalhousie University
Outstanding Cadet - 2nd Phase	-	O/Cdt CM Mason	- University of Alberta

Capt to Maj Qualifying Course - 18 Sep - 27 Oct 61

Capt	DG	Gardner	-	11 Coy
Capt	HG	Bunston	-	12 Coy
Capt	GMD	Conrad	-	12 Coy
Capt	CD	Mollins	-	12 Coy
Capt	WF	Shaw	-	12 Coy
Capt	VM	McMaster	-	12 Coy
Capt	JLY	Cyrenne	-	13 Coy
Capt	DR	Girard	-	13 Coy
Capt	HF	MacKay	-	13 Coy
Capt	GIJ	Bisaillon	-	14 Coy
Capt	JOL	Bourget	-	14 Coy
Capt	RJ	Bryant	-	14 Coy
Capt	HJ	Cashin	-	14 Coy
Capt	BA	Gaudet	-	15 Coy
Capt	GT	Crossman	-	4 Fd Dent Coy

DT Lab Instr Course - 25 Sep - 20 Oct 61

Sgt	RL	Thornton	-	11 Coy
Sgt	WF	Chase	-	12 Coy
Sgt	AM	Jerome	-	13 Coy
Sgt	JE	Raymond	-	13 Coy
Sgt	BH	Sims	-	13 Coy
Sgt	AC	Vout	-	13 Coy
Sgt	KPH	Buchholz	-	14 Coy
Sgt	GE	McGunigal	-	14 Coy
Sgt	G	Shechosky	-	14 Coy
Sgt	M	Tremblay	-	15 Coy
Sgt	KS	Rothwell	-	35 Fd Dent Unit

DT Lab Gp 4 Course - 23 Oct - 1 Dec 61

Sgt	EE	McFadden	-	11 Coy
Sgt	RL	Thornton	-	11 Coy
Sgt	DB	Wood	-	11 Coy
Sgt	RJ	Goodwin	-	13 Coy
Sgt	WE	Hill	-	13 Coy
Sgt	AM	Jerome	-	13 Coy
Sgt	JE	Raymond	-	13 Coy
Sgt	KLM	Wallace	-	13 Coy

DA Instr Course - 18 Sep - 6 Oct 61

Cpl	LR	Barrett	-	12 Coy
S sgt	PAA	Egan	-	12 Coy
Sgt	SG	Fraser	-	12 Coy
Sgt	RF	Matheson	-	12 Coy
Sgt	EL	Schell	-	12 Coy
Cpl	HD	Wagstaff	-	12 Coy
Sgt	BW	Holtham	-	13 Coy
Sgt	W	Olynyk	-	13 Coy
Sgt	W	Richardson	-	13 Coy
Sgt	RK	Shappee	-	13 Coy
Sgt	TH	Southin	-	15 Coy
Sgt	ES	Knoll	-	RCDC School

No 1 Dental Equipment Depot

Dent Eqpt Rep Gp 2 - 4 Sep - 15 Dec 61

Sgt	RG	Hopkins	-	15 Coy
Sgt	AJ	Tait	-	1 Dent Eqpt Dep

Dent Stmn Gp 2 - 16 Oct - 24 Nov 61

Cpl	GM	Wadden	-	12 Coy
Pte	DH	McKay	-	13 Coy
Pte	RE	Thompson	-	15 Coy
Pte	PJ	Dumas	-	1 Dent Eqpt Dep
Pte	HE	Lubitz	-	1 Dent Eqpt Dep
Cpl	DT	McRoberts	-	1 Dent Eqpt Dep

RCASC School, Camp Borden

Sr NCO Courses

A/Sgt	G	MacCuish	-	12 Coy
Cpl	WE	Bussell	-	13 Coy
Cpl	HM	McCurdie	-	13 Coy
Cpl	FJ	Reid	-	14 Coy

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Dental Technicians Clinical

There are at present 20 DT Cls in the Corps. In the 1960/61 fiscal years these tradesmen performed 54,015 operations valued at $158,202.00.

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DT Lab Gp 4 Course - 23 Oct - 1 Dec 61

Sgt	EE	McFadden	-	11 Coy
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Sgt	DB	Wood	-	11 Coy
Sgt	RJ	Goodwin	-	13 Coy
Sgt	WE	Hill	-	13 Coy
Sgt	AM	Jerome	-	13 Coy
Sgt	JE	Raymond	-	13 Coy
Sgt	KLM	Wallace	-	13 Coy

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Sgt	RF	Matheson	-	12 Coy
Sgt	EL	Schell	-	12 Coy
Cpl	HD	Wagstaff	-	12 Coy
Sgt	BW	Holtham	-	13 Coy
Sgt	W	Olynyk	-	13 Coy
Sgt	W	Richardson	-	13 Coy
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RCASC School, Camp Borden

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VITAL STATISTICS

DIRECTORATE OF DENTAL SERVICES

Hospital:

Sgt Doug Lillico was admitted to Rockcliffe Hospital on 26 Sep.

Mrs Smallshaw was recently hospitalized for a tonsilectomy.

THE RCDC SCHOOL

Hospital:

Lt Col JW Turner in Toronto Military Hospital 3 Aug - 5 Sep 61.

NO 1 DENT EQPT DEP

Obituary - S sgt Dick Claydon

Funeral services were held in Ottawa on 3 Aug 61 for the late S sgt Dick Claydon who died suddenly in Ottawa on 31 Jul 61. S sgt Claydon, a dental storeman, was a veteran of 20 years with the Corps having served in Canada, Europe and Korea. He is survived by his wife and one son who reside in Ottawa.

Births:

To Lt and Mrs EA Church on 18 Jul 61 a daughter, Patricia Leah.
To S sgt and Mrs JW Hutchinson on 30 Jun 61, a daughter, Catherine Mae.
To Pte and Mrs HE Lubitz on 30 Sep 61, a son, Gregory Harvey John.

NO 11 DENT COY

Marriages:

Capt M Petryk was married to Miss Patricia Mae Winnick at Edmonton on 15 Aug 61.

NO 12 DENT COY

Births:

Major and Mrs IW Susser - a son, Michael Benjamin
Sgt and Mrs JF Marchand - a daughter, Lynn Marie
Cpl and Mrs JC Bleakney - a daughter, Jill Leah
Cpl and Mrs EV Tanner - a daughter, Gail Elaine

NO 13 DENT COY

Marriages:

Major PS Sills was married to Miss Ada Elaine Joynt at Ottawa on 29 Jul 61.

Capt MN Deyette was married to Miss Marilyn Eloise Nodwell at Mansville, Ont on 12 Aug 61.

Capt AJC Vachon was married to Miss Catherine Luella Phillips at Ottawa on 5 Aug 61.

Capt PJJ Coulombe was married to Miss Charlotte Lorraine Caron at Leaside, Ont on 16 Sep 61.

Capt RL Moran was married to Miss Dolores Patricia Long at Fort William, Ont on 29 Jul 61.

Births:

To Major and Mrs PL Falkner on 10 Aug 61, a daughter, Christine Elizabeth.

To Capt and Mrs EW Gazo on 14 Jul 61, a son, John Michael.

To WO2 and Mrs BA McLeod on 4 Aug 61, a son, Allan Donald Joseph.

Hospital:

S sgt WB Weir - returned to duty after six months in hospital and six weeks' sick leave.

Cpl NAJ Eady - 14-18 Aug 61.

NO 14 DENT COY

Hospital:

Sgt A Bramble - Fort Churchill Hospital 7-13 Sep 61, Deer Lodge Hospital 18-27 Sep 61.

Sgt GA Fogg - Deer Lodge Hospital 18-29 Sep 61.

Sgt GE McGunigal - Shilo Hospital 19-26 Sep 61.

NO 15 DENT COY

Births:

To Capt and Mrs JH Marion on 7 Sep 61, a son, Joseph Henri Sylvain.

Marriages:

Capt PP Prud'homme was married to Miss Therese Crete at Herouxville, Que on 31 Jul 61.

Cpl AE Werkmann was married to Miss Therese Majchozak at Montreal on 15 Jul 61.

LAW MLH Gamache was married to LAC La Rue in July.

Sickness:

S sgt CR White has graduated to a walking cast after a period on crutches owing to a broken ankle while playing softball with the RCAF Stn St Jean team.

Pte Ferland is now out of hospital on convalescent leave following a hernia operation.

Mrs J Lecompte, civilian DA in Montreal has been ordered to take one month's rest.

35 FD DENT UNIT

Marriages:

LAW Joncas was married to LAC Ridley on 31 Aug 61.

4 FD DENT COY

Births:

To Sgt and Mrs Ron D'Eon on 9 Sep 61 at BMH, Iserlohn, a daughter, Heather Lynn.

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DIRECTORATE OF DENTAL SERVICES NEWS

Corps Service in France Honoured

The RCDC has shared in a signal honour conferred on Canadian Units and Services who served in France during the Second World War.

A symbolic ceremony was held in Quebec City in September, 1960 when Countess Hettier de Boislambert, patroness of the Regiment de la Chaudiere presented a small chest containing soil collected from Canadian Military cemeteries in France to His Excellency, The Governor General of Canada. Le Regiment de la Chaudiere of Levis, P.Q. one of the units which took part in landings on D-Day, was chosen as custodian of this symbolic chest. This Regiment expressed the wish that all Canadian Units and Services who fought in France during the Second World War should share this honour and accordingly each has now received a replica of the chest complete with a portion of the French Soil. The chest presented to the RCDC will be retained permanently at The RCDC School.

Brigadier Baird Attends Important Meeting

Brigadier Baird attended a meeting of the Sub-Committee on Dental Auxiliary Training of which he is a member, in Toronto on September 25, following which he visited The RCDC School to inspect Corps personnel and facilities.

Colonel Shillington at ADA Convention

Colonel GB Shillington journeyed to Philadelphia to attend the American Denture Society Meetings on October 13 and 14 and the American Dental Association Convention on the 16th and 17th.

Oral Health Meetings

Majors JC Brick and DH Protheroe represented the Director General of Dental Services at meetings of the Editorial Board of Oral Health magazine held in Toronto. Major Brick attended in October and Maj Protheroe in September.

Maj Protheroe Participates in Research Conference

Maj Protheroe presented a paper entitled "Dental Research in the Royal Canadian Dental Corps" at the First Canadian Conference on Dental Research in Toronto on 30-31 Oct.

RCDC Golf Tournament

The annual RCDC Ottawa Area Golf Tournament was held at the Glenlea Golf Club on 3rd October. Participants included personnel from the Directorate, No 1 Clinic NDHQ, No 14 Clinic Rockcliffe, No 17 Clinic Uplands, and No 24 Clinic HMCS Gloucester. Top honours went to Sgt (Bill) Hill with an 81 followed by Major Andy Andrews with an 84 and Sgt (Jim) Minnelli with an 86.

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THE RCDC SCHOOL NEWS

Lt Col Bagnall Essayist at EODA Convention

Lt Col SG Bagnall was a guest lecturer at the Eastern Ontario Dental Association Convention held at the Chateau Laurier, in Ottawa 17-19 Sep 61. The title of his presentation was "Complete Denture Patient Remount Technique". This lecture supported by a film describes the technique which new or unsatisfactory complete dentures can be remounted on an adjustable articulator for the correction of occlusal disharmony.

Cdr RR Troxell - Exchange Officer from USNDC

Cdr RR (Dick) Troxell USN DC joined the staff of The RCDC School on 15th August 1961, to become the first "exchange" officer to serve with the Corps. He will head the Department of Restorative Dentistry at The RCDC School. A native of Kansas City, Missouri, Cdr Troxell graduated from Northwestern University Dental School in Chicago in 1946. He joined the US Navy Dental Corps the same year and has served aboard several US Navy ships at home and abroad coming to the School from the USS Everglades in Charleston, South Carolina. From January 1955 until October 1959 he served on the staff of the US Naval Dental School, National Naval Medical Center, Bethesda, Maryland. This is not the Commander's first visit to Canada. In 1957 he appeared as an essayist before the Montreal Dental Club. He is a member of the Editorial Board of the Journal of the Academy of Gold Foil Operators, and the American Academy of Crown and Bridge Prosthodontics. He has appeared as an essayist and clinician before several large Academies in Boston, New York City, Chicago and Washington DC and has had articles published in the Journal of Prosthetic Dentistry.

Cdr and Mrs Troxell and their three children are now residing in married quarters in Camp Borden.

Lt Col Turner - Exchange Officer to USN Dental School

Lt Col JW Turner became the first RCDC exchange officer to serve with the USN (DC) when he was posted to the Staff of the US Navy Dental School, Bethesda, Md for a one-year tour.

RCDC School Wins Noble Trophy

Not to be outdone by the School Volleyball team in bringing laurels to the School, the School golf team took to the fairways in September and walked off with the Noble Trophy, emblematic of the Unit Team Championship in Camp Borden. Eleven teams competed for the coveted trophy and when the aggregate scores were finally tallied only sixteen strokes separated the top and bottom teams.

The School team of Major Jim Wright, Capts Chas Casterton and "Van" Van Ryssel and WO 2 Tommy Batten captured the silverware with an average net score of 68. The RCASC School placed second just one stroke behind the winners.

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NO 1 DENTAL EQUIPMENT DEPOT NEWS

Dent Eqpt Dep Takes in CGS Hand-Over Ceremonies

The week of 25 Sep 61 began with a flurry at No 1 Dental Equipment Depot. Major Fletcher started it off with an inspection of the personnel and ended up by leading the unit on a Garrison Parade in the hand-over ceremony of the Chief of the General Staff. After inspecting the troops of Camp Petawawa on what was his last parade, Lieutenant General S.F. Clark, CBE, CD, handed over the Command of the Army to Major General G. Walsh, CBE, DSO, CD. After the ceremony the officers retired to the Mess for a farewell luncheon.

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NO 11 DENTAL COY NEWS

Duty Trips and Visits

Colonel BP Kearney has completed his initial tour of inspection of all clinics in the Company.

Major RJK Pyne and Sgt VH Shaw proceeded to RCAF Station Holberg on 8 Sep for a 3-week period to provide treatment for personnel and dependents at that location. Sgt Shaw returned early in order to prepare for his posting to 4 Fd Dent Coy.

Sgt GH Taylor was employed at RCAF Station Penhold during the first part of August while Pte WW Webster was on leave.

Cpl J Dion proceeded on TD to RCAF Station Sea Island 19 Aug to 4 Sep to assist Capt JO Bowman until Sgt WD MacDougall arrived.

Capt LC Gray was on TD from Vancouver to Namao pending Major JCE McDonald's arrival on 25 Sep 61.

Lt Col OW Crummey, QMS (WO 2) EK Abernethy, S sgt H Hodkinson and Sgt GF Keogh spent two weeks at Camp Wainwright in September.

Major TD Cobb, Sgt WJ Arnsby and Pte BA Green left in early October for a two week trip to Dawson Creek and Fort Nelson, providing treatment at these northern stations. They travelled by mobile to Dawson Creek and used the facilities of a civilian airline for the side trip to Fort Nelson.

Sgt Thornton Builds Own Aircraft

Sgt Ralph Thornton has recently completed an ambitious "do-it-yourself" project in that he built his own aircraft.

Sgt Thornton estimates that he spent 3,500 hours in constructing the plane and says that having an understanding wife is essential in such an undertaking.

For those interested in vital statistics, the aircraft weighs 725 pounds with pilot and full fuel tanks; has a wing-span of 23 feet; cruising speed is approximately 120 miles per hour; and it takes off at about 45 m.p.h. with less than 200 feet of runway.

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NO 12 DENTAL COY NEWS

Unit Officers Attend Meetings

Col AT Roger represented the GOC Eastern Command at the opening of the Lunenburg Fisheries Exposition on 12 Sep 61. Col Roger also attended the Atlantic Provinces Dental Convention held at Charlottetown PEI. Major JI Gordon and Capt WF Shaw presented Table Clinics at this convention. Their topics were "The Alter-Cast Technique for Partial Dentures" and "Replantation of Traumatically Avulsed Teeth" respectively. Major TC Gaudet presented a paper at the North Shore NB Dental Society entitled "The Role of the Dentist in National Disaster and Casualty Care". Capt JF Mullins made an inspection of dental clinics in New Brunswick Area during this period.

Farewell for Major Gordon

The Halifax Area officers held a farewell party aboard HMCS Bonaventure for Major "Ike" Gordon on the eve of his departure for No 15 Coy. Ike has been our "swinger" for years and his spot will be difficult to fill.

New Civilian Dental Assistant

Mrs Margaret Roberge is now employed at HMCS Stadacona as replacement for Mrs Melody Wirth who resigned her position.

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NO 13 DENTAL COY NEWS

Major Chatwin and WO 2 Sherry Receive Gold Medallions - Label to Sgt Holtham

Major JVP Chatwin and WO 2 Sherry qualified and have received their Gold Mdeallions from St John Ambulance. Sgt Holtham BW has gone a step further and qualified for the St John Ambulance Label. Congratulations.

Farewell for Capt Coulombe

A farewell party was held by Major LR Pierce at RCAF Stn Clinton for Capt and Mrs PJJ Coulombe prior to his departure for 4 Fd Dent Coy.

13 Coy Sports

Cpl Loosley DB was picked to represent Camp Petawawa at the Central Command Golf Tournament held at London, Ont 7 - 8 Sep 61. Don tied with a 77 in the leading round for Petawawa team. The Petawawa team average of 83.5 placed them fifth in the five-team match.

In a tournament for the AOC's Trophy, Station Trenton won over teams from 6 RD and ATCHQ. Capt Gazo had the low score on the winning team with an 83.

In the RCAF Inter-Station Tournament held at the Ottawa Hunt Club, teams from Trenton, Downsview, North Bay and Uplands competed. RCAF Trenton won the tournament and our boy Gazo with a score of 81 placed 3rd in the individual standing.

No 1 Clinic, NDHQ, Ottawa

Front Row - L to R: Miss Hyndman, Maj Donely, Lt Col Cornish, Mrs Aubin, Mrs Ruffo

2nd Row - L to R: Cpl Thrasher, Sgt Brown, WO 2 Mann, S sgt Heard

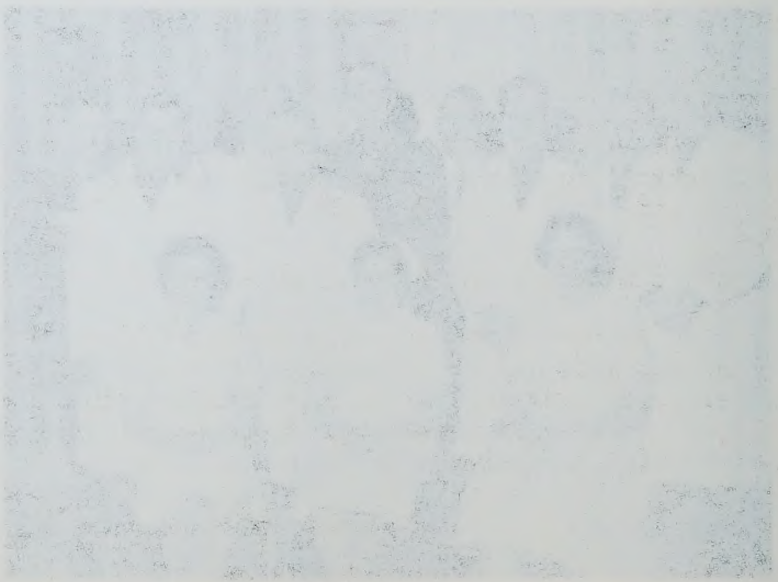
3rd Row - L to R: Sgt Minnelli, Sgt Hill, S sgt Therrien

Nos 4, 7 & 13 Clinics, Kingston

Front Row - L to R: Mrs Ball, Mrs Brown, Mrs Debicki

2nd Row - L to R: Sgt Holtham, WO 2 Sherry, Cpl McCurdie, Sgt Shappee

3rd Row - L to R: Sgt Raymond, Dr MacGowan, Col Leman, Maj Chatwin, Dr Duff and Capt Cyrenne



No 3 Clinic, Camp Petawawa

Front Row - L to R: Capt Doiron, Lt Col Anglin, Capt Deyette

2nd Row - L to R: Sgt Tremblay, Cpl Boucher, Mrs Van-Scherrenburg, Sgt Goodwin

3rd Row - L to R: S sgt Fraser, Sgt Adams, Cpl Dawson, Cpl Loosley

Dental Clinic, RCAF Station Aylmer Closed

No 20 Dental Clinic, RCAF Station Aylmer was closed, the equipment removed and returned to Trenton on 13 Sep.

★★★★★★★★★★★

NO 14 DENTAL COY NEWS

Trips and Visits

Lt Col RB Jackson and Lt HF Doyle made a liaison visit to CJATC Rivers, HQ Camp Shilo and RCAF Station Portage la Prairie on 24 to 25 Aug, RCAF Station Saskatoon, HQ Sask Area Regina and RCAF Station Moose Jaw on 28 to 31 Aug to inspect dental facilities. Lt Col Jackson and Capt GJ Moore visited HQ Fort Churchill on 11 to 13 Sep.

Majors LA Richardson and JA Lauziere attended a meeting of the Winnipeg Dental Society on 2 Oct 61.

Sports

The 14 Coy RCDC Bowling League with six teams, comprising RCDC personnel in the Winnipeg Area has once again commenced its activities with strikes and spares the order of the day.

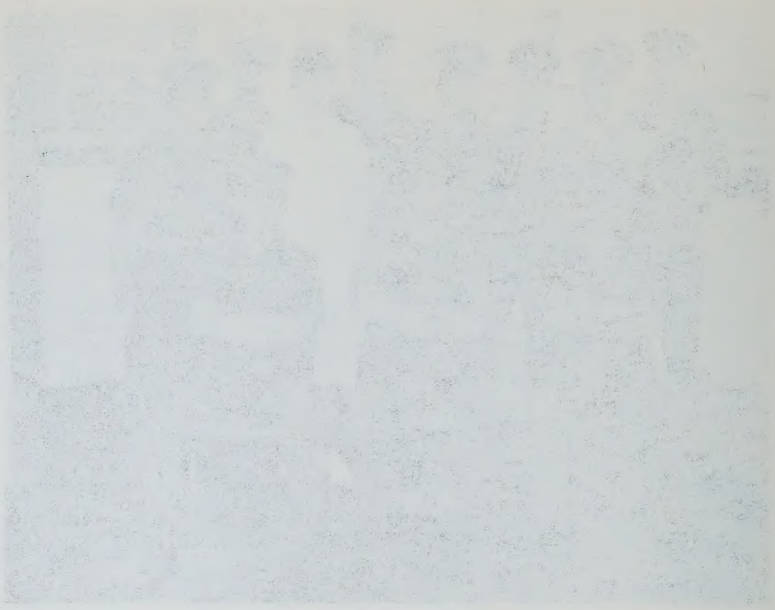
57 Dental Unit (M) Celebrate Trelford Trophy

A special party was held by No 57 Dental Unit (M) on 6 Oct 61 in Minto Armouries, with all RCDC personnel in the Winnipeg Garrison invited to attend, to celebrate winning the Trelford Trophy. The CO of 14 Dental Coy who was unable to attend, was represented by Major LA Richardson, and it is understood that a good time was had by all.

★★★★★★★★★★★

Subsidization Figures

Since the start of the RCDC undergraduate subsidization programme in Sep 1948, 203 dentists have been graduated. There are 57 subsidized students attending university.



15 DENTAL COY NEWS

Duty Trips and Visits

Capt L Jacob and Sgt RG Hopkins recently returned from a duty trip to St Therese, Que; Sgt Hopkins and S sgt CR White spent a week's duty in Goose Bay in August; Capt JWR Harrison and Sgt JP Carrier recently returned from 7 days' TD in St Jerome at Target Area Headquarters; and Capt JL Masse and Pte JAY Ferland returned in Jul from a summer vacation at Camp Gagetown.

Officers Attend Farewell for General Rockingham

The farewell reception in honour of Major General and Mrs Rockingham on the eve of their departure for Western Command was attended by Lt Col Butler, Capt and Mrs Harrison and Capt and Mrs Marcil.

Sports

All golfing members of the unit are still attempting to lower their handicaps now that the season is on the wane. Capt Parent of St Jean won the RCAF Stn Class "C" Championship. Capt Harrison of HQ took second low gross in the Montreal Area Army Championship. Under the chairmanship of Lt Col Butler the HQ Quecom golf enthusiasts enjoyed a fine season. It was considered an honour that Capt Parent and L/Sgt Jermain were chosen as members of the RCAF St Jean golf team which recently competed for the Training Command Championship at Camp Borden.

☆☆☆☆☆☆☆☆☆☆☆

35 FD DENT UNIT NEWS

Unit Personnel in UK

During the period 12-17 Sep, Lt Col LG Craigie and Capt DH Evans proceeded on temporary duty to the United Kingdom. The purpose of their visit was to inspect clinic facilities at 30 AMB Langar and at CJS London, where a new clinic has been completed, and to finalize details for the early despatch of a dental detachment to both locations. S sgt LA Lawson and Cpl WJ Parker also visited these clinics during the latter part of September to complete the installation of X-ray equipment in the CJS clinic and to carry out a clinic equipment check at Langar.

Unit Personnel Tour Europe

The usual "trek" of personnel to other countries continued during the summer months. The favourite location for annual leave seemed to be Italy and the French Riviera although England, Scotland and Denmark took their share of the "long green" from our vacationers.

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FIRST AID TRAINING

Over 90% of Corps personnel are trained to certificate or higher level in first aid.

☆☆☆☆☆☆☆☆☆☆☆

4 FD DENT COY NEWS

Duty Trips and Visits

Lt Col Evans visited No 35 Fd Dent Unit at No 1 Air Division, Metz, France during the first part of Aug on the occasion of the unit hand-over to Lt Col Craigie.

Capt GT Crossman proceeded to Canada 15 Sep 61 to attend The RCDC School Capt to Maj Qualifying Course.

Accommodation

A new dental clinic is in the process of being constructed at Fort Beausejour and the relocation of the dental laboratory from Fort Anne to Fort St Louis has been completed.

* * * * * * * * * * * *

DENT DETACHMENT CBUME NEWS

Capt Lanthier Tours Europe

Capt Rolly Lanthier is on an extended tour of Europe in a brand new Mercedes-Benz before settling down in No 1 Clinic, Ottawa.

Duty Trips and Visits

Major MacDonald, the retiring Senior Dental Staff Officer, accompanied Major Small on a familiarization tour of the various Contingent dental clinics, including the Swedish, Brazilian, Norwegian, Danish and Yugoslavian.

On 3 Aug Capt Lanthier went with the Medical Team on a duty tour of the International Frontier, giving emergency dental care to several Bedouin.

Accommodation

The laboratory section has been completely renovated, with a new tile floor, new benches, and paint. The credit goes to the laboratory staff, as they did most of the work themselves. The men's quarters have been repainted and renovated and now is the pride of the detachment and the envy of all other personnel in the Camp.

Personnel Visit Vocational Centre

On 19 Aug personnel from this detachment visited the UNRWA Vocational Training Centre at Gaza. This agency has, as one of its functions, the training of Palestinian refugees in arts and crafts to assist them in becoming useful citizens. Each year the public is invited to an exhibition of painting, weaving and sculpture. The various articles on display may be purchased, and the proceeds go to further the work of the agency. During this tour several of our personnel bought items from the exhibit as souvenirs.

CBUME "Cook-Out"

On 16 Sep, HQ Coy CBUME, including the Dental Detachment, held a steak barbecue at Camp Rafah outdoor theatre. The event began promptly at five o'clock with the officers serving the men, and ended about ten o'clock with the singing of "Auld Lang Syne". The party was very successful, and made a welcome break in the otherwise rather monotonous routine of daily life in the Middle East.

Leave

During the month of August, Sgt Johnny Christiansen went on a four-day tour of Cairo, and upon his return entertained the Detachment with his accounts of the cultural points of interest, including the Pyramids, Sphinx, Museum and Zoo.

Cpl Joe MacPhee went to the Leave Centre, Beirut, for seven days, and came back loaded with "loot" from the local bazaars. On the strength of Cpl MacPhee's recommendation, S sgt Harvey Reid also went on leave to Beirut, and his description of the University and the many beautiful churches and mosques revealed a keen interest in the more elevating aspects of Lebanese culture.

Another member of our group who qualifies for the "Beirut Star" is Capt Doug Bunt. He highly recommends the various tours available from the Leave Centre, and asserts that they are the highlights of a Middle East posting.

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GENERAL EFFICIENCY COMPETITION RCDC(M) - 1961

The results of the 1961 General Efficiency Competition for the RCDC(M) are as follows:

The Moore Trophy, which is awarded to the unit judged to be most efficient during the training year, was won by No 61 Dental Unit (M), Vancouver, commanded by Lt Col FK Currie.

The Trelford Trophy, which is awarded to the militia unit judged to be runner-up in the competition, was won by No 57 Dental Unit (M) with headquarters at Winnipeg. Lt Col MJ Snidal is commanding officer.

The Saskatchewan Dental Association Memorial Trophy, which is presented to the militia unit most improved in general efficiency, was awarded to No 56 Dental Unit (M), Toronto commanded by Lt Col AZ Henry.

Congratulations are extended to the winners and honourable mention is made concerning the efficiency of No 50 Dental Unit, Halifax; No 51 Dental Unit, Saint John; No 55 Dental Unit, London; and No 60 Dental Unit, Edmonton.

☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆ ☆

WE GET LETTERS - TOO!!!

A recent communication received at this Directorate reads:

"I beg to apply for new dental plates as I have been informed that the Govt will replace them for new dentures.

I had all my teeth extracted before I left the service after 25 years. I retired on pension on the 30th of November 1938."

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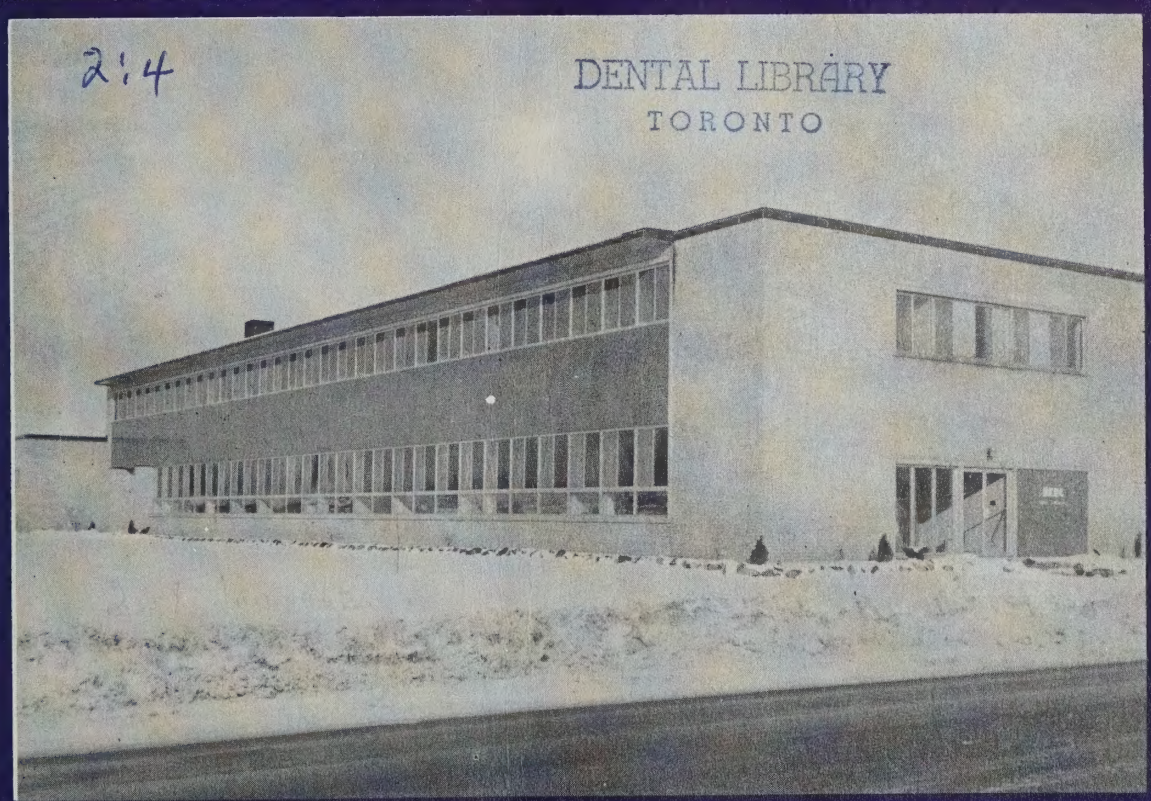
The ROYAL CANADIAN DENTAL CORPS Quarterly



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Cover Photo - The Royal Canadian Dental Corps School, Camp Borden, Ontario.

Editor's Note:

The following reply to the "Toast to the Ladies" is printed in this issue of the Quarterly through the kind permission of Mrs. A.C. Leman who presented it on the occasion of the Corps Mixed Formal Dinner held at the Gloucester St. Officers' Mess, Ottawa, Ont on 5 December 1961.

HONOURED GUESTS, BRIGADIER BAIRD, LADIES AND GENTLEMEN:

On behalf of the ladies present I would like to thank the speaker Major Brick for the proposed toast and his kind words and on my own behalf also thank him for introducing a subject, the lot of the service-wife, on which I want to say a few words. After twenty-one years of being one, I have been thinking back a little, analysing, and wondering, however, I don't intend to take the twenty-one years day by day.

The role of a service-wife is not on the whole an easy one. We are not in the Service and yet we are "of it". Uprooted time and time again, we must start afresh and create for our families a haven of peace and rest and comfort, no matter where we might be unceremoniously plunked down, and no matter what the materials might be with which we have to work. Like Ruth in the Bible we follow our man and "whither thou goest I shall go ... and thy people shall be my people". At times rather than of Ruth, I have thought of Stanley Holloway singing in "My Fair Lady" about the neighbour who comes a-calling "With a little bit of luck, with a little bit of luck, when he comes around, you won't be in".

Certainly there have been difficulties. I remember particularly the plaster coming down on the dining room table, the water freezing when spilt on the kitchen floor up in the Yukon, the balky, contradictory French furnace refusing to draw and the irate French landlady waving her hands above her head in exasperation and vowing that it was all our fault because Canadians didn't know how to manage a furnace. (When I got to know the french language a bit more I realized that she always waved her hands about and spoke vehemently even when she was saying the nicest things.) The scratched favourite coffee table, the stair carpet short by three steps, the drapes short by three and a half inches. The neighbour's dog in the newly planted flower-bed and the horrid little landlady's son reading comics by the hour in the bathtub of the shared bathroom. We've all had these experiences, and plenty more like them and doubts assail us about the new places and new people and new problems.

But as a tribute to our husbands and a return of the compliment, and in spite of our trials and tribulations, there has also been much fun. It has been interesting, and it has been a good way of life. There is an exhilaration that comes from meeting a challenge and beating a problem which I think keeps us young in spirit.

I remember one day in Whitehorse during the Christmas season that I had baked 240 dinner rolls with a great deal of enthusiasm for all the parties and festivities of the Yuletide season. There were buns all over the place and what to do with them was a bit of a problem! We finally rigged out a barrel on

pulleys and hung it up on a tree, safely away from the packs of malamute dogs roaming the district and filled it with our dinner rolls. It made a perfect deep-freeze in 35 below zero weather and whenever we needed some rolls we pulled down the barrel.

I remember another time, and this emergency measure happened in quite a civilized part of the country, the power went off for the day. We were expecting 12 dinner guests from one hundred miles away and there was a very raw looking 30 lb. turkey to cook. Of course the mess and the neighbours couldn't help as they were in the same fix. We took the bird downtown to various restaurants in the little town nearby, but no one wanted to tie up his oven with our dinner. At last we took it to our cleaning lady who cooked it for us to perfection. The vegetables were done on a Coleman stove and with the fireplace lit and a hot dinner ready for our guests when they arrived we were all ready, having brought back the turkey wrapped in a blanket in the car for warmth. The Leman menu of "Turkey in a Blanket" and "Beans a la Coleman" was the laugh of the Loop, but we were very pleased that our guests didn't even know that anything was wrong until we told them.

In our travels we have an opportunity for building friendships which enrich our lives, not only in Canada, but in other parts of the world. In our postings we can develop new interests and receive new ideas. The roots which we sometimes mourn are, after all, not lodged in the neighbouring buildings but within ourselves and in our families wherever they are.

And then there is something else. Something which was exemplified for me recently in a very moving and beautiful ceremony at the air station where we are now living. It was a change-over of the AOCs and while the guests sat watching in their summer finery, the troops were grouped on the parade square and an excellent band played marches. After the general salute and the inspection, the signing over took place and then slowly, the pennant of the AOC who was leaving was lowered from the masthead. A hush fell over us all as we watched. The AOC was pale and tense with emotion as his pennant was rolled up and presented to him. He saluted, turned, and left with it tucked under his arm and for the space of a moment the parade square became a little blurred for some of us. The troops were re-grouping and at first I thought they seemed to be milling about without direction and then suddenly they wheeled about to attention in front of their new Commander whose pennant by now was flying in place at the masthead.

I glimpsed then, I think, something "bigger", the "whole" of the thing, the continuity of the service, and I was suddenly proud that my husband belonged to this "whole" and that I, through him, was also a part of it.

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MARRIAGE? - AN ACT OF FOLLY!

The following is an extract from the Standing Orders of the 72nd Highlanders of 1873 reproduced from the Canadian Army Journal Vol XV No 4 1961:

> "It is impossible to enumerate half the miseries which are the inevitable result of marriage to a soldier; officers, therefore, cannot do too much to dissuade their men from it; there are but few men who will not, in after years thank in their utmost hearts, the officer or friend who kept them from such an act of folly; indeed, it ought to be sufficient to point out to such men what some of their married comrades are daily undergoing, to prevent them subjecting themselves to a similar misery."

* * * * * * * * * * * *

THE CORPS - 1961

Brigadier KM Baird, OBE, CD, DDS, QHDS, FICD

A review of our activities for 1961 may not appear as spectacular as the one for 1960 but it nevertheless discloses an effort that has been productive and rewarding. A part of what has been accomplished is not expected to become manifest until some years hence and must be considered as a long-range investment. The short summary that follows is intended only to outline the more immediate results and to depict our position at the present time.

The overall strength of the Corps was increased slightly in spite of a small reduction in dental officers, with a total of 54 personnel taken on strength and 48 struck off strength. Our civilian numbers remained constant but there was a gain in RCAF airwomen and in RCDC other ranks. However the Dental Officer Subsidization Plan, authorized during the past summer has produced the largest number of undergraduate enrolments in our history with a promise of even a wider response in the coming year when the benefits of the plan are fully publicized.

Those who diligently follow the seniority list may be somewhat surprised at the number of promotions which have come about since our last report was published. Eleven dental officers progressed to higher rank and one Warrant Officer Class I was commissioned in the rank of Lieutenant. Amongst the other ranks there was a total of 42 promotions including all levels from Corporal to WO 1 inclusive.

The training programme for 1961 was an exceptionally busy one for both the Militia and the Regular components. Dental units of the Canadian Army Militia, in addition to their Local Headquarters Training, had 18 officers on the Casualty Care Course at The RCDC School and seven on the Captain Qualifying Course Part 2. Five RCDC(M) other ranks were on attachment to the School as well. The Militia, of course, also conducted summer camps under command and unit arrangements where a total of 74 all ranks were trained. The General Efficiency Competition this year produced some new winners with the edge going to our Western units. It was gratifying to note that all units participated in the 1961 competition which had not been the case for the past several years.

In the RCDC Regular, 17 officer candidates underwent the Pre-Course Study Programme for qualification to the rank of Major and of these, 15 attended the Qualifying Course at The RCDC School. In the undergraduate programme, 46 ROTP and subsidized candidates attended the various practical phases during the summer at either our own School or the Royal Canadian School of Infantry. Qualifying courses for other ranks included 11 candidates on the Sr NCO Course and 7 on the Jr NCO Course.

Commanding Officers of RCDC Regular units are no doubt fully aware that a large number of their personnel were involved in technical or professional dental training. Trades training at our Corps School included 69 candidates of which 34 were dental assistants, 30 laboratory technicians and five clinical technicians. No 1 Dental Equipment Depot, in addition had eight for training as dental storemen. Professional training for officers was conducted at The RCDC School; at Canadian and US Universities; at US Service Schools and the Royal College of Surgeons in London, England. Thirty-three officers were provided with this post-graduate training which comprised courses varying in duration from one to 16 weeks and included all phases of clinical dentistry as well as the basic sciences. Papers and demonstrations were presented to professional meetings by eight Regular dental officers. National Survival training came in for its share of emphasis with certification of a further 13 officers and 19

other ranks in the St John Ambulance First Aid. This brought our Regular Corps status in qualified officers and other ranks to 96.1%, and 93.5% respectively. There were 22 officers and 52 other ranks trained in other phases of National Survival at either the Corps School; the Canadian Forces Medical Service Training Centre; the Civil Defence College at Arnprior or in Commands and Depots. These latter courses raised our Regular Corps status in officers and other ranks who have received such training to 68.1% and 43.5% respectively.

The programme for equipping and supplying the Corps with technical items proceeded in accordance with the long-range policy. The funds available for this purpose were expended to good advantage and many of the obsolescent major items of equipment were replaced by more efficient models. For example, 23 motor operating chairs, 42 oral evacuators, 44 airotors, 23 operating units, 25 X-ray machines and 79 dry heat ovens were procured and distributed during the year. The Stores Committee had for consideration 111 items and initiated investigation projects on 56 items of which 14 were recommended, 13 were still under test and 29 were not deemed acceptable.

Accommodation for the Corps was improved considerably with the opening of five new clinics; the renovation of a further eight, and the relocation of the headquarters of 4 Field Dental Company in Germany in improved facilities. New construction for Camps Valcartier and Petawawa is in the planning stage and there is hope that these projects may develop in the foreseeable future.

In the provision of dental services our achievement was maintained at a high level. The time-points ratio for dental officers per duty day was up slightly from last year and reached an all-time high for the Corps. Clinical technicians as well, continued to extend their effectiveness and demonstrated an increased productivity in all phases of their service, including prophylaxis, radiographs, total operations and patients. It is evident from this that all auxiliary personnel in the clinic, in the laboratory, in the stores and in the orderly room, are contributing with greater effect. The only area of concern in the overall treatment picture is in the field of periodontal treatment where, in spite of an increased emphasis on preventive dentistry, there continues to be a gradual decline. On analysis, the reason for this may prove to be statistical but it may be that further attention to this field will be necessary in future courses at the Corps School.

Finally, the Dental Health Education programme is producing encouraging results and is gaining wider acceptance by Service personnel and more enthusiastic support from the Corps members. Additional literature and more recent films are providing impetus to the project which ultimately should prove to be of benefit to all who participate.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

DENTAL PRACTICE

"Twenty-five or thirty years ago dental practice was limited to relieving pain and treating lesions of the teeth, the gums and other tissues of the mouth. Today it is concerned with the comprehensive management of oral, facial and speech defects and with the oral structures and tissues as they relate to the total health of the individual. Good dentistry in 1960 calls on the practitioner not only to prevent the occurrence and progression of dental diseases, but a search as well for oral pathological changes that provide early indications of systemic diseases".

Robert G. Kessel, D.D.S., M.S.
College of Dentistry, University of Illinois

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THE RCDC SCHOOL

Lt Col SG Bagnall, CD, DDS

The RCDC School has been operating for almost fifteen years and has gone through many stages of development. Many of the more recent members in the Corps perhaps are not aware that their School had a wartime counterpart. The requirement for technical training facilities for Dental Corps personnel was recognized early in the Second World War. The Canadian Dental Corps Technical Training Centre was established at 14 Spadina Road, Toronto in 1943 and during its two years of operation, courses of one to six weeks' duration in professional subjects and trades training were conducted. In all, a total of 116 refresher courses were conducted for 1232 all ranks of the Corps.

Early in the post-war period it became obvious that there was a requirement for a school to conduct Special-to-Corps training in peace time. This was realized in 1947 with the establishment of the Royal Canadian Dental Corps School at 541 Sussex Street in Ottawa. Although the accommodation and facilities left much to be desired, the energy and persistence of the staff under the direction of Lt Col KM Baird, resulted in the development of training courses which are the basis of our present training programme.

Lt Col KM Baird, now Brigadier and Director General of Dental Services for the Canadian Forces, retained command of The RCDC School until July 1952, when he was succeeded by Lt Col WE Meldrum. Lt Col GB Shillington, now Colonel and DDGDS, was appointed Commandant in June 1953 to be succeeded by Lt Col IAL Millar, now Colonel and DDS, the following year. When the School moved to its present location in 1957, Col BP Kearney was appointed Commandant and retained command until July, 1961 when Col CE Purdy assumed command.

Repeated demands for larger and better facilities finally met with the approval of the authorities and construction commenced in 1956 for the accommodation currently occupied. The new RCDC School at Camp Borden was taken over and occupied in June 1957. It was officially opened by the Honourable George R. Pearkes, VC, Minister of National Defence, on 13 June 1958 in the presence of a distinguished gathering of service and civilian guests. This was a proud and memorable day in the history of the Corps.

Added functions and increased responsibilities have caused the expansion of the school staff to more than twice its original establishment. Although training is the primary function of The RCDC School, a treatment wing is included for the provision of dental services for personnel located at Camp Borden. With the introduction of National Survival Training in the Canadian Army, courses were established in 1959 for the training of RCDC officers and tradesmen in their Special-to-Corps role. Stores investigations, special projects, publications, trade tests, assessments and reviews are a few of the additional functions of the unit.

As a unit located in a military camp The RCDC School is required to accept its share of responsibilities in the administration and organization of camp and community activities by providing representation or leadership to several committees. Over the years a vast number of visitors, both civilian and military, from Canada and abroad have visited The RCDC School to examine the physical facilities and study its training methods.

The relocation of the School in Camp Borden with additional training facilities enabled the Corps to enlarge the scope of many of the courses. This

is especially true in the summer training programme for undergraduate dental students. Subjects such as drill, field exercises and survival training provide the young officer and officer cadet with a much broader knowledge of military and Corps subjects.

Summer training for officer cadets is carried out in two phases. Each phase consists of ten weeks. The first half of the initial phase is primarily a familiarization period and is conducted at Naval and Air Force units. During this period the undergraduate is taught the customs of the three Services, the functions performed by the various components of each and, in particular, his function after graduation as a member of the RCDC serving one of these components. The remaining five weeks of his initial phase is spent at The RCDC School on Special-to-Corps training including instruction in military dentistry.

The undergraduate spends the entire ten weeks of the final phase of his training at the Corps School. Three weeks of this training is Special-to-Corps military subjects, one week National Survival Training and six weeks' clinical indoctrination.

It is fairly common during these summer training periods to have undergraduates on course representing every dental college in Canada. Many of the young officers take good advantage of this opportunity to exchange ideas, compare notes and engage in free discussion on a variety of topics related to their profession and chosen careers.

The School provides a common meeting place and aids in the development of an esprit-de-corps for many members scattered amongst the various units of the Canadian Navy, the Army and the Air Force in Canada and abroad. Since its inception in 1947 a total of 153 courses have been conducted with a total enrolment of nearly 1600 candidates. This accomplishment has unquestionably benefited the Services, the individual and Canadian dentistry.

COURSES AT THE RCDC SCHOOL

The following is a statistical report on courses conducted at The RCDC School since its inception in 1947. These figures are felt to present an interesting view of the School's principal activities over the years.

TYPE OF COURSE	NUMBER HELD	TOTAL CANDIDATES
Officers - CA(R)		
Officers Clinical	31	191
Lt to Capt Qualifying	3	35
Capt to Maj Qualifying	9	74
Command Dental Officers	1	6
Officers Advancement Training	1	11
Officers Casualty Care	3	21
Practical Phase Training - ROTP - Subsidized - COTC	16	307
TOTAL	64	645

TYPE OF COURSE	NUMBER HELD	TOTAL CANDIDATES
Officers - CA(M)		
Senior Officers Qualifying	6	56
Dental Officers Indoctrination	1	5
Militia Officers	4	186
Militia NCOs	1	5
TOTAL	12	252
Dental Technician Clinical		
Group 3	5	25
Group 4	3	16
TOTAL	8	41
Dental Assistants		
Dental Assistant Instructors	6	58
Group 1	23	273
Senior Dental Assistant	2	18
TOTAL	31	349
I&A Cadre		
I Staff	2	16
Dental Technician Laboratory		
Dent Tech Lab Instructors	7	62
Group 1	7	71
Group 3	13	110
Group 4	8	49
TOTAL	35	292
QM		
QMS Course	1	3

Total Courses Held - 153

Total No of Candidates - 1598

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TYPE OF COURSE	NUMBER HELD	TOTAL DURATION
Officers - C(A)		
Senior Officers Qualifying	6	54
Dental Officers Indoctrination	1	5
Militia Officers	4	180
Militia NCOs	1	4
TOTAL	12	238
Dental Technician Clinical		
Group 3	5	25
Group 4	1	16
TOTAL	6	41
Dental Assistants		
Dental Assistant Instructors	6	30
Group 1	25	275
Senior Dental Assistant	1	10
TOTAL	32	349
RCA Corps		
I Staff	2	16
Dental Technician Laboratory		
Dent Tech Lab Instructors	7	60
Group 1	7	72
Group 3	13	130
Group 4	8	40
TOTAL	35	292
CM		
CMC Course	1	3

Total Courses Held - 122

Total No of Candidates - 1598

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HABITS AND MALOCCLUSION

John Abra, D.D.S.
Consultant to the RCDC in Orthodontics

An acquired habit, from a psychological point of view is nothing but a new pathway of discharge formed in the brain, by which certain incoming currents ever after tend to escape. Habits in relation to malocclusion perhaps should be classified as either useful or harmful. Useful habits should include the habits of normal function, such as correct tongue position, proper respiration and swallowing and normal use of the lips in speaking. The harmful habits include all that exert perverted stresses against the teeth and dental arches as well as those habits such as open mouth habit, lip biting, lip sucking, thumb sucking etc.

Thumb sucking and finger sucking are of importance because of the concern they cause parents. The dentist to whom the alarmed parents come for advice is often as confused about the significance of the practise as are the parents themselves. He finds it difficult to help them or allay their fears. In order to do this successfully he is in need of a working knowledge of the significance of the habit at different age levels. He needs to know what harm, if any, may result; what factors lead to the development of the habit, and what measure should or should not be taken to handle the situation adequately.

The newborn infant has a relatively well developed mechanism for suckling. From it he receives not only his food but also a feeling of well-being, a sense of security, a feeling of warmth of association and of being wanted. To advise a parent to break up a finger or thumb sucking habit during the first year and a half to two years ignores the basic physiology of infancy. Since young children must continually adapt to new environments, some children will accept the restriction and turn quickly to more mature forms of satisfaction. Many children, however, will not, and the habit is made more pronounced so that it does not disappear as easily as it might have done if left alone. Constant badgering of the child by the parent to keep his fingers out of his mouth sometimes gives the child a potent weapon--an attention-getting mechanism. The child quickly learns that this is a fine way to attract attention and uses it accordingly.

For the first three years of life, experience has shown that damage to occlusion is confined largely to the anterior teeth. This damage is usually temporary, provided the child started with a normal occlusion. Some of the damaging consequences of the sucking habit are similar to the characteristics of a typically hereditary protrusion of the upper teeth. Hence it is easy to assume that this condition along with the retrusive mandible is caused entirely by the habit whereas a careful examination of both parents teeth may show that the child came by the condition honestly without any help from the thumb.

The permanence of the malocclusion increases markedly in children continuing the habit beyond three and a half to four years. The increase in overjet that goes with so many finger habits make normal swallowing increasingly difficult. Instead of the lips containing the dentition during swallowing, the lower lip often slips in lingual to the upper incisors forcing them further forward. Since we swallow about once a minute all day long the condition can become progressively worse even after the actual sucking habit has been overcome.

The TRIDENT of habit factors is:

Duration
Frequency
Intensity

Duration of the habit beyond early childhood is not the only detriment. Equally important are the frequency of the habit and the intensity. The child who sucks occasionally or just when going to sleep is much less likely to do any damage than is one who has his fingers in his mouth constantly. The intensity of the sucking is most important. Some children seem to have the finger or thumb lying passively in the mouth while others can be heard in the next room. Parents tell of removing a thumb from the mouth of a sleeping child producing a noise as loud as the "Pop" of a cork coming out of a champagne bottle.

The damaging consequence of these habits is apparent. One of the most valuable services a dentist can give is to help in overcoming these pernicious habits. This is often more easily said than done, but with patient understanding of the underlying cause and quiet but forceful talks to both child and parent, a great deal can be accomplished. If it is evident that co-operation is not going to be obtained from either one or both parties, then the suggestion should be made that the pediatrician or even a psychiatrist should be visited. No effort should be spared to break the childish habit before the eruption of the permanent teeth. If this is not accomplished the child at best will require months of expensive orthodontic treatment and, at worst, have an unsightly and unhealthy mouth for the rest of its life.

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ENDODONTICS AND THE DENTAL ASSISTANT

Cpl WA Jackson

Endodontics is a branch of dentistry that in recent years has gained much prominence and it is imperative that dental assistants be familiar with the drugs and techniques commonly used. This article is, therefore, directed to the DA and his role in this field of dental science. More especially, it is hoped that it will answer some of the questions that arise in his mind respecting materials, equipment, and procedures and thus enable him to better fulfil his duties as assistant to the dental officer.

The practice of endodontics involves a number of important considerations not commonly included in other aspects of dentistry. While the following does not pretend to present a comprehensive list, it does include a few facts with which the DA may not have had an opportunity of acquainting himself.

The one thought that must remain constantly in mind is that all instruments and materials entering the canal must be sterile. Understandably then, if the root-canal instrument case is to remain sterile, the cotton pliers must be flamed immediately prior to each entry into the case; the lid should be opened no further than necessary to retrieve the instrument required and closed again as soon as possible. As the assistant reads on he will find that the greater portion of his duty is to provide, prepare, and present materials and instruments that are sterile.

Root-Canal Case

The first item of equipment to be considered is the root-canal case. (Fig 1) This is issued on an allotment of one per full-time dental clinic. Like most dental equipment, it is expensive and careful handling is required. Finger marks and smudges may be removed by means of an alcohol swab.

The instruments should be arranged in the removable tray according to the dental officer's preference, but the normal practice is to store the long-handled files numbered in increasing progression (ie 15, 20, 25, 30, 40 and 50) from left to right. In the shorter compartments the short-handled files are stored in the same series and the long-handled instruments numbered 60, 70 and 80 placed in the small space between the box and the compartment for the long-handled No 15 files. The additional small spaces on the right may be used for round and flame burs and paper points. Since the case does not provide space for cotton pellets, broaches, and straight-handpiece surgical burs, small trays of aluminum to accommodate these can be readily constructed.

The stainless steel slabs, spatulas, spreaders, Bowley gauge, and/or any special measuring device, are placed in the remaining unused portion of the instrument tray. The stainless steel slabs are used in lieu of the conventional glass slabs since they can be hot-sterilized without breaking.

The suggested number of files in each compartment is six. Files are now available with color-coded handles. The different file sizes have different colored handles which offer immediate detection of a file which has been placed in the wrong compartment.

Trays and contents, with proper care in handling, will remain sterile for one week; at the end of this period the entire unit should be re-sterilized.

Dry Heat Sterilizer

The second important item of equipment is the dry heat sterilizer, listed in the stores catalogue as OVEN, dry heat complete with temperature control. This item also is issued at present on an allotment of one sterilizer per full-time dental clinic. Care must be taken to operate it at the correct temperature of 320° F as the solder on the files melts at 350° F and a lesser temperature will result in incomplete sterilization. The sterilization period is 1½ hours. The lid of the oven should not be lifted once sterilization has begun as the unit tends to over-compensate for the heat loss. The instrument case is placed on the top shelf of the sterilizer to prevent overheating by radiation from the element in the bottom of the oven. Overheating, in addition to melting the solder in the instruments, scorches or burns the cotton pellets and the paper points. The sterilizer must be cleaned by daily dusting or wiping with a damp cloth since immersion of the unit or controls in water is contra-indicated. As only dental equipment is placed in this oven, its interior requires a minimum of care.

Rubber Dam and Clamps

The dental assistant must have in readiness all items required for the application of the rubber dam. The main variation from operative dentistry is that only the tooth undergoing treatment is isolated and after the dam is in place, the field of operation is sterilized with a disinfectant such as untinted metaphen.

Radiographs

The KV, MA, exposure time, and angulations used are recorded on the Treatment Record. The recording of these details makes it possible to make the follow-up radiographs which approximately duplicate the original.

As radiographs are made during the period of the patient's appointment, speed is essential in order that the dental officer may proceed as soon as possible with the next step in the procedure. In this regard the dental officer may request a modified processing technique for quicker viewing.

Patient Record

The dental assistant should keep a list of endodontic patients, showing all service particulars, local telephone number, date on which treatment began, number of treatments, and date of completed restoration. This record is of value not only to the dental officer but also to the dental assistant to provide a dependable reference for recalling the patient six months after completing the restoration.

Drugs and Materials

The dental assistant must be familiar with the following drugs and materials which are used in endodontics.

1. Camphorated Paramonochlorophenol is often sealed in the canal as a dressing between appointments. This drug is made available by dispensing it from a dappen dish, or direct from an eyedrooper, to the paper point.

2. PBSC derives its name from the initials of its contents, viz, penicillin, bacitracin, streptomycin, and sodium caprylate. This dressing is introduced into the root canal with a blunt needle. The needle, stylus, and carpule are provided in the same box. It is the dental assistant's responsibility to maintain a clean, clear needle. After cleaning, it is necessary to sterilize the needle and place it in the surgery drawer ready for its next use. If for some reason the needle clogs, the stylus that is provided is used to clear the blockage.

3. Sodium hypochlorite (NaOCl) is used as an irrigating agent to remove debris from the canal. It is made up by diluting three parts of Javex (7% NaOCl) with one part water. The result is a 5% solution.

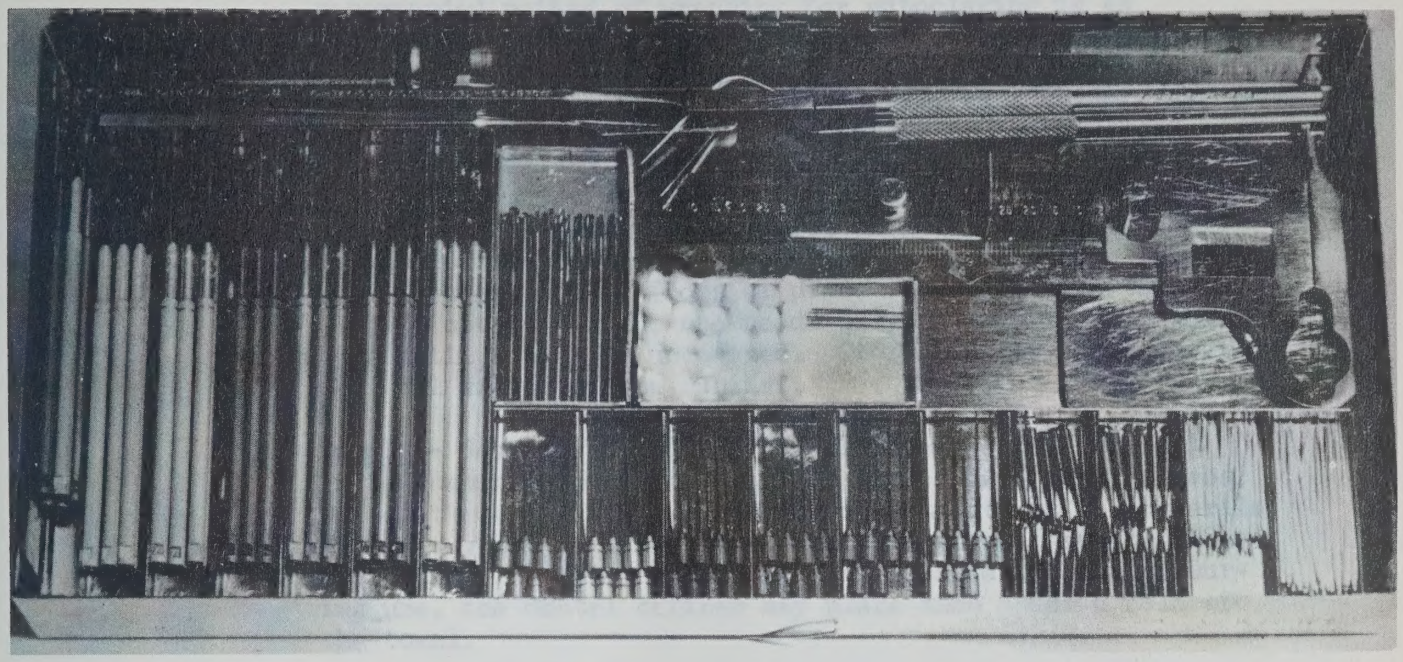
4. Hydrogen Peroxide is used in conjunction with sodium hypochlorite for the removal of debris from the root canal.

   The dental officer and his assistant should arrive at a dappen-dish "code" which is mutually satisfactory, as the three above-mentioned solutions, viz, camphor, paramonochlorophenol, sodium hypochlorite, and hydrogen peroxide are to all intents and purposes colorless. The system in use at The RCDC School has proven satisfactory; amber being used for the CMCP, green for the NaOCl, and white for the H_2O_2. By standardization of these medicaments with a certain colored dappen dish, the dental officer knows immediately the contents of each.

5. Root-Canal Sealer - regardless of the brand in use, the DA must ensure that he is completely familiar with the mixing instructions enclosed with each package.

Fig 1

ROOT CANAL INSTRUMENT CASE



6. Metaphen (untinted) - This solution has the same antiseptic quality as the tinted metaphen, but does not have the staining effect. It is dispensed in a Petri dish and used to sterilize the rubber-dam field and Gutta Percha points. The Petri dish is also an excellent place to put a few rubber stops where they are readily accessible to the dental officer.

7. Rubber Stops - These may be made from ordinary 1/8 inch wide elastic bands cut into 1/8 inch squares, each of which is punched centrally with the rubber-dam punch. The punch is set at the smallest hole. These stops may be stored in a small sealed bottle in untinted metaphen. As mentioned above, they are best dispensed in a Petri dish.

8. Dehydrating Solution - This is used for cleaning and drying the pulp chamber prior to a bleaching procedure and is made up of three parts alcohol and one part chloroform.

9. Superoxol - This is a 30% aqueous solution of H_2O_2, and is the bleaching agent used in the bleaching procedure. It is caustic and the following precautions must be observed:

   - keep tightly capped when not in use,
   - avoid contact with the skin,
   - keep refrigerated, and
   - handle carefully.

10. Xylene (xylol) - This is an excellent solvent for cleaning files, reamers, barbed broaches, spreaders, etc. It is available through medical stores.

    CAUTION: For use only in a well-ventilated area as the fumes are harmful.

11. Swabs - These are made up of a large pledget or tuft of cotton on a wooden applicator. They are used to spread the untinted metaphen on the rubber dam field. Any suitable method of autoclaving these swabs is acceptable. A recommended method of wrapping for autoclaving is as follows:

> Using the length of a dental towel, as a guide, lay the swabs in a row at right angles to the sides of the towel and about half an inch apart. When this has been accomplished, fold both sides of the towel into the centre over the row of swabs. Roll up the towel and swabs and secure the towel roll with towel forceps, dental floss or pins. Now autoclave the roll. To obtain a swab, one needs only to unroll the towel until a swab is uncovered. Store the roll in a surgical drawer of the cabinet.

12. Towels - Several autoclaved dental towels should be kept in the cabinet, preferably in the same drawer as the swabs. One of these will be used during each treatment as a sterile field on which to place those instruments that are to enter the canal. Further, to protect the broaches and files during use, the dental officer may place them under a fold of the towel.

13. Flame - An alcohol or gas flame is needed for the flame sterilizing of many of the endodontic instruments and the softening of Gutta Percha temporary stopping. The dental assistant will be required to make this available during root-canal treatment.

This outline of endodontic procedures is intended to supplement whatever knowledge the dental assistant already possesses. Additions or variations may be prescribed by the dental officer. By close co-operation with the dental officer, the dental assistant will find that he can share in the satisfaction that comes when an endodontic operation is brought to a successful completion.

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The following is an excerpt from a report submitted by Maj WH Murray, Camp Borden on a course in Endodontics he attended recently at the University of Michigan, Ann Arbor, Michigan:

> "New Developments, Drills and Doctrines which it is considered should be included in the training of the active or reserve forces
>
> Sterilization of carious dentin by the use of a mixture of penicillin and camphorated parachlorophenol was strongly advocated in preventive endodontics as a more conservative alternative to the present routinely used calcium hydroxide preparations, since with the former preparation less secondary dentin is formed in the healing process thus allowing more favourable conditions for subsequent root canal therapy if such should ultimately be necessary."

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11. Points - These are made up of a long pointer or part of cutting on a wooden applicator. They are used to spread the activated substance on the rubber dam. Any suitable method of activating these units is acceptable. A recommended method of securing for activating is as follows:

12. Towels - Several sterilized dental towels should be kept in the cabinet, preferably in the drawer at the left of the chair. One will be used during each treatment as a sterile field on which to place those instruments that are to enter the canal. Further, to protect the trousers and clothing, the dental officer may place this paper towel over his lap.

13. Floss - A strand or two floss is needed for the floss stretching of each of the endodontic instruments and the collecting of loose debris becoming crowding. The dental assistant will be required to have this available during root-canal treatment.

This setting of endodontic procedures is intended to supplement whatever knowledge the dental assistant already possesses. Additions or variations may be prescribed by the dental officer. By close co-operation with the dental officer, the dental assistant will find that he can share in the satisfaction that comes when an endodontic operation is brought to a successful conclusion.

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The following is an excerpt from a report submitted by Maj Ott Harvey, Corps Dental Officer, to the Commanding General, Army Service Forces, Washington, D.C., on the Dental Service of the Army Air Forces:

"New Developments. Devitalization of dentin by the use of a mixture of penicillin and camphorated paramonochlorophenol has strongly advocated in preventive endodontics as a more conservative alternative to the present routinely used calcium hydroxide preparations, where with the former preparation less secondary dentin is formed in the healing process thus allowing more favorable conditions for subsequent post canal therapy if such should ultimately be necessary."

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A REVIEW OF CURRENT LITERATURE ON INFECTIOUS HEPATITIS AND ITS RELATIVE, SERUM HEPATITIS

Major RE Dyer, CD, DDS

15 Died, Doctor Is Charged

CAMDEN, N.J. (AP)—A pathologist for the Philadelphia medical examiner's office testified Wednesday that an autopsy he performed on one of Dr. Albert Weiner's patients showed death was due to phosphorous poisoning.

Weiner, 43-year-old Erlton osteopathic psychiatrist, is on trial in Camden County court on manslaughter charges in connection with the deaths of 15 of his patients.

The state charges all 15 died of serum hepatitis, a liver disease, contracted through unsterile needles and syringes used by Weiner.

The pathologist, Dr. Joseph E. Campbell, examined by prosecutor Norman Hein, insisted he could not testify as to cause of the poisoning since he had not been sworn as an expert witness.

The defence alleges death could have been from other forms of the liver disease, including toxic hepatitis, caused by drugs.

The clipping at left is taken from the Halifax Mail Star, November 2, 1961. As these court actions are becoming more common, it is time that members of the dental profession learned how to prevent the transmission of viral hepatitis and thus protect themselves and their patients from the effects of this disease.

While the existence of the infectious hepatitis and serum hepatitis viruses are well established we cannot as yet fulfil Koch's Postulates with them. A situation such as this can give rise to false assumptions from available evidence.

The high incidence of infectious hepatitis and its near relative serum hepatitis provided the military with one of its more serious problems in the Second World War. The concept of infectious hepatitis has undergone drastic changes since the early days of the war. Today it is viewed as a viral infection which is becoming more and more prevalent, particularly in children and young adults. It is characterized by destructive changes in the liver, occasionally a severe illness in the adult and usually a mild illness in children, often so mild as to pass unrecognized. The severity of infectious hepatitis is known to be increasing among adults, and seems to be greater in women than in men. Serious chronic complications of acute infectious hepatitis seem to develop more readily in females than in males. Follow-up studies of Service personnel who contracted hepatitis have failed to show any increase in cirrhosis in later years.(1) However, recent studies among civilian groups indicate that infectious hepatitis may lead to serious chronic liver disease (2).

Much of our knowledge of the causative agent or agents is derived from intensive studies using human volunteers as experimental subjects. While both infectious hepatitis (IH) and serum hepatitis (SH) are believed to be caused by viruses, none have been isolated to the extent of being grown on a laboratory host and then being able to reproduce the disease in man. At the present time man appears to be the only susceptible host. Knowledge of these infections will accumulate rapidly when a successful experimental host is discovered and a specific diagnostic test is found. The present laboratory tests are only aids in the diagnosis of infectious hepatitis and must be properly applied and properly interpreted. Recently, determinations of serum enzymes have been applied with considerable usefulness to the differential diagnosis of jaundice. The most widely used of the enzyme tests has been the determination of the serum transaminases. However, it must be remembered that no specific laboratory test for infectious hepatitis exists. Even the histologic findings of needle biopsy specimens from the liver are not absolutely diagnostic of this disease. (3)

The rapidly changing concept of this infection mentioned above began in the early days of the Second World War, when the German investigator Voegt (4)

15 Died, Doctor Is Charged

reported the first successful transfer of infectious hepatitis from man to man by oral feeding. British workers first demonstrated the presence of a virus in the blood (5) and in stools. (6)

The virus agents of infectious hepatitis are present in the blood and stools of infected people during the incubation period two to three weeks before the emergence of hepatitis and during the acute phase of the disease. (7 & 8). With regard to the presence of the viruses in blood and stools after recovery of the victim, the evidence is rather inconclusive at this time. Capp, Bennett and Stokes (9) report the presence of the virus in the stools of two patients with chronic hepatitis five months and fifteen months respectively after the onset of the disease. Neefe, Stokes and Rheinhold (10) have failed to detect a virus in stools in as little as three weeks after disappearance of the jaundice. Murray and his associates (16) demonstrated viremia in one person eight months after recovery and at a time when all liver function tests were normal. In view of the above, it would appear that a good deal more investigation is required into the matter of virus retention in the post-recovery period.

It has long been suspected that infectious hepatitis occurs in most people as a non-apparent (subclinical) infection. A six-year old child was fed infectious hepatitis material and observed daily thereafter for two months. During this time, he had no fever, no symptoms, no enlargement of the liver, no jaundice, no bilirubinuria, no abnormality of the serum bilirubin, thymol turbidity or cephalin flocculation. The only change detected in the patient was a rise in the serum glutamic oxalacetic acid transaminase on the thirty-seventh day. Serum obtained on this day was injected into eight persons, six of whom developed hepatitis, three with jaundice, three without, after incubation periods of 33 to 47 days (7) . With the above it is evident that the most potentially dangerous carrier would be the young person with a subclinical infection (9).

There is much evidence pointing to the intestinal oral pathways as the principal methods by which infectious hepatitis spreads. Although water (11), milk or food outbreaks have been reported, it is believed that direct human association is the prime factor. Indeed, in a report on the outbreak of infectious hepatitis in the Kenora area of Ontario in 1958-59, Dr R.D.P. Eaton said, "There was no proof of any mode of spread other than by direct contact. Water, milk and food supplies were not incriminated". (12)

In connection with this report, Dr Eaton's table of the incidence of infectious hepatitis by age and sex in this outbreak should be of interest. It is attached as Table 1.

While most of the available evidence of hepatitis transmission through dental procedures deals with serum hepatitis (15) we must bear in mind that infectious hepatitis may also be introduced into the body by parenteral injection.(13) The virus is present in the blood during the incubation period and the acute phase of the illness, and a strong possibility of viremia (16) exists in the post recovery period. This, complicated by the likelihood of a sub-clinical infection in the young, makes a second mode of transmission apparent. It is an artificial one and, like serum hepatitis, it can be transmitted by contaminated needles and syringes, (14) in fact by any penetrating instrument used in medical or dental procedures.

Since infectious hepatitis and serum hepatitis run such parallel clinical courses, it would be wise at this time to compare the two viruses. One of the differences between the two is a different incubation time. Infectious hepatitis takes a period of 2 to 8 weeks while serum hepatitis is much longer, 8 - 26 weeks. The

incubation period of infectious hepatitis appears to be unaffected by the size of the dose or by the portal of entry of the virus.

A comparison of the two viruses is outlined in Table 2 compiled by Ward, Krugman and Giles. (8) On close examination of this table several deductions can be made:

1. Any method of sterilization that is satisfactory for serum hepatitis will also be effective for infectious hepatitis.

2. The resistance of serum hepatitis to ether and merthiolate solutions plus its unknown reaction to coagulation, combined with the resistance of infectious hepatitis to ether and chlorine, one part per million, throws doubt on the wisdom of using cold sterilizing solutions.

3. Heat appears to be the best method for prevention of parenteral spread of infectious hepatitis and serum hepatitis from the carrier to our patients.

With respect to the above, in a comprehensive consideration of the problem of virus-caused hepatic infections, Perkins (17) claims that brief exposures to boiling water or immersions in chemical solutions are inadequate. He also stresses that the National Institute of Health stipulates that all instruments capable of transmitting serum hepatitis should be sterilized by one of the following methods:

1. Autoclaved for thirty minutes at 121° C (15 lbs pressure)

2. Dry heat at 170° C for two hours

3. Boiled for thirty minutes

The above list is prepared in order of descending efficiency and 30 minutes of boiling is the least permissible method. It should be pointed out at this time that the carpule system is not recommended for thick or viscous suspensions because of the difficulty of flushing out the lumen of the needle. Indeed it appears that the more viscous the injected material the less reliable the boiling method becomes, unless a very thorough mechanical flushing of the needle and syringe can be done.

Other deductions which may be drawn from Table 2 and the various writings referred to earlier in this paper are:

1. Infectious hepatitis is present in the stools as well as the blood. It is transmitted orally or parenterally but the prime method of transmission is by direct contact of people. In any outbreak it is very difficult, if not impossible, to trace the origin to a parenteral transmission.

2. Serum hepatitis viruses are present in the blood and transmitted parenterally only. Any outbreak of serum hepatitis can be traced to penetrating wounds within the incubation time - often many cases to the same office and that office alone.

3. There is some doubt as to the degree of immunity conferred by an attack of virus-caused hepatitis and the following observations are made:

a. One attack of infectious hepatitis generally confers immunity against further attacks. However in a study of 525 cases over a six-year period, 4% had second attacks (8). These recurrences might be explained by:

(1) the existence of multiple types of infectious hepatitis virus

(2) the primary infection by the virus becoming dormant, only to be re-activated by some unknown factors

(3) persons having a deficient immunity mechanism or the immunity being overwhelmed by a massive dose of virus in the second illness.

b. As pointed out in Table 2, evidence of immunity to serum hepatitis virus is rather inconclusive at this time.

4. Gamma globulin prepared from normal adult sera will suppress the severity of hepatitis as manifested by the appearance of jaundice. This power of gamma globulin indicates the presence of an antibody or antibodies with broad protective powers. In the literature available to this writer the terms "icteric" and "anicteric" hepatitis made their appearance in conjunction with gamma globulin prophylactic measures. Rather than discuss infectious and serum hepatitis separately the writers combined them and spoke of hepatitis with (icteric) and without (anicteric) jaundice.

Since subclinical carriers are the most potentially dangerous, the most effective measures which can be used in dental clinics to prevent the transfer of the disease are listed below:

1. A high standard of personal cleanliness for clinic staffs.

a. Careful washing of hands with a good soap before eating, after bowel movements and after each patient.

b. Suppression of flies, cockroaches and other insects in offices and homes. (This is aimed at breaking the intestinal oral pathways of infectious hepatitis)

2. Boiling all penetrating instruments for thirty minutes. Chemical solutions are inadequate.

3. All instruments, particularly serrated types such as burs and hemostats must be cleaned of all debris before sterilizing.

4. A dentist should have a sufficient number of syringes on hand to ensure that they can be sterilized for thirty minutes between their use and re-use.

5. Always discard any anesthetic or drug carpules once used regardless of the amount of solution left in the carpule.

6. As chlorination of water supplies does not destroy the infectious hepatitis virus (if present) never wash out a wound with tap water, particularly if there is any outbreak of infectious hepatitis in the area.

7. In case management of patients with infectious hepatitis or serum hepatitis and those with a history of hepatitis, disposable needles and syringes should be used. Also aseptic surgical principles should be followed in all routine procedures. (A fissure bur can lacerate gingival tissue during cavity preparation)

8. In the event of suspected exposure to infectious hepatitis or serum hepatitis gamma globulin should be given. Dosage - 2 ml per lb. of body weight.

TABLE I (12)

Incidence by age and sex of Infectious Hepatitis Cases

Age	Male	Female
0-4 years	14	12
5-9 "	50	42
10-14 "	26	30
15-19 "	19	5
20-24 "	8	13
25-29 "	7	16
30-34 "	5	11
35-39 "	7	4
40 plus	4	5
Totals	140	138

TABLE 2 (8)

Comparison of Infectious Hepatitis (I H) and Serum Hepatitis (S H) and diseases caused by them

Characteristics	I H Virus	S H Virus
Size	Unknown - passes Seitz EK filters	about 26 mu
Temperature resistance -15 to -20° C.(2 yrs & 4 mos)	Remains active	Remains active
Room Temperature - 6 months	--	Remains active
56° C., 1/2 hrs	Remains active	Remains active
60° C., (140° F) 4 hrs	--	Remains active
60° C., 10 hrs	--	Inactivated

TABLE 2 (8) (cont'd)

Characteristics	I H Virus	S H Virus
Resistance to ether	Remains active	Remains active
Resistance to merthiolate 1:2000	--	--
Resistance to chlorine 1 ppm	Remains active	--
Coagulation, settling filtration & chlorine	Inactivated	--
Susceptible Host	Man	Man
Pathologic changes	Same	Same
Season of year	Fall and Winter	Any
Age	Children and young adults	Any
Incubation period	2 - 8 weeks	8 - 26 weeks
Clinical features	Same	Same
Secondary cases	plus	0
Virus in stools	plus	0
Virus in blood	plus	plus
Virus transmitted parenterally	plus	plus
Homologous immunity	plus	plus (x)
Heterologous immunity	0	0
Gamma globulin supresses jaundice	plus	?

(x) Inconclusive - evidence indicates that it is inferior to that for infectious hepatitis.

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RCDC ACCOUTREMENTS

It may not be generally known that a complete stock of accoutrements for RCDC personnel is maintained at The RCDC School. These include ties ($3.50), belts ($2.65), scarves ($5.00), crests ($5.00), lanyards (.60¢) anodized buckles ($2.50) anodized buttons (large .12¢, medium .10¢, small .09¢) and badges (hat gilt $3.50, collar gilt $4.50, titles $1.25, pips brass .75¢, crowns brass $1.00, pips cloth .50¢, crowns cloth .85¢). Orders, accompanied by a money order, may be placed through Dental Unit Commanding Officers. It is worth noting that Corps scarves have been reduced in price from $8.00 to $5.00.

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BOOK ACCOUNTMENTS

To may not be generally known that a complete stock of accountments for RCDC personnel is maintained at The RCDC School. These include ties ($3.50), belts ($2.65), scarves ($5.00), overts ($5.00), lanyards ($.60) anodized buttons (large .35¢, medium .30¢, small .20¢) and badges (not gilt $1.50, collar gilt $2.50, titles $1.25, pipe bras .75¢, crowns brass $1.00, pipe clutch .50¢, crowns cloth .85¢). Orders, accompanied by a money order, may be placed through Dental Unit Commanding Officers. It is worth noting that Corps scarves have been reduced in price from $8.00 to $5.00.

CORPS CONFERENCES - 1947-61

Captain Ernest Clark, BEM, CD

In October, 1946 the Royal Canadian Dental Corps became an authorized component of Canada's peace-time Army. Four months later in January, 1947 the first DGDS and Unit Commanders' Conference was held at Army Headquarters, Ottawa. Since that meeting there have been only three years in which a Conference has not been held--1949, 1951 and 1958. The most recent meeting was held in December, 1961 and marked the twelfth time that the Director and Staff have met with unit commanders to discuss mutual problems and to seek ways and means to improve the status of the Corps in the fields of dental treatment, stores and equipment and in personnel administration.

The Agenda of the 1947 Conference lists only three unit commanders (11, 12 and 13 Coys) who were located geographically outside the Ottawa area. By comparison, and emphasizing the expansion of the Corps, those attending later Conferences represented units in Halifax, Montreal, Camp Petawawa, Trenton, Camp Borden, Winnipeg, Edmonton and 35 Fd Dent Unit in France and 4 Fd Dent Coy in Germany.

1961 Corps Conference

Front Row - L to R: Col BP Kearney; Col IAL Millar; Brig KM Baird; Major-General JDB Smith; Col GB Shillington; Col AC Leman

Middle Row - L to R: Col CE Purdy; Lt Col GR Covey; Maj JC Brick; Col AT Roger; Maj AW Brusso; Lt Col DH Hillier; Cdr RR Troxell USN (DC)

Back Row - L to R: Lt Col RB Jackson; Capt E Clark; Maj JW Fletcher; Lt Col JG Butler; Maj DH Protheroe; Capt WJ Bignell

From time to time, new departures were added such as the inclusion of members of the Dental Advisory Staff so that the ties with the RCDC Militia might be strengthened. In 1952 and again in 1960 unit quartermasters were listed among those present at the Conferences to facilitate discussion of problems connected with the supply of stores and equipment.

Although the years have brought changes in personnel and have increased the varieties of problems presented for discussion, each conference has in itself contributed to the growth and development of the Corps and has helped to bring all units of the Corps closer.

The 1961 Conference was as successful as any that preceded it. A full agenda testified to the thought and energy of those participating. Decisions were reached on many of the items discussed and in several instances these decisions have already been promulgated in instructions to units. The Minutes of the Conference have been published and distributed to all concerned.

The Conferences have not been without their social aspects, the highlight being a formal mixed dinner or alternately, a regular Mess Dinner. There are, of course, informal get-togethers as time permits. During the 1961 Conference, a formal mixed dinner was held at the RCAF Officers' Mess, Ottawa and preceding the opening of the Conference, Colonel and Mrs GB Shillington held "open house" for those attending. All those attending the social functions enjoyed the festivities immensely.

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PROMOTIONS

Congratulations are extended to the following officers and men on their recent promotions:

Major	GE	Windsor	- to Lt Col
Capt	GIJ	Bisaillon	- to Major
Capt	RJ	Bryant	- to Major
Sgt	HEG	Franzgrote	- to S sgt
Sgt	R	Pelletier	- to S sgt
Sgt	JM	Tapp	- to S sgt
Cpl	EV	Tanner	- to Sgt
Cpl	RJ	Lowery	- to Sgt
Cpl	HM	McCurdie	- to Sgt
Pte	CVS	Forsythe	- to Cpl
Pte	A	Pink	- to Cpl

WELCOME

A hearty welcome is extended to the following new members of the Corps and RCAF Airwomen:

Pte	TJ	Deloughery	- The RCDC School
Pte	RJ	Forward	- Recruit Training, Camp Petawawa
Pte	RB	Johnson	- The RCDC School
Pte	RG	Moffatt	- Recruit Training, Camp Petawawa
Pte	PD	Whynott	- Recruit Training, Camp Petawawa
Pte	RJ	Gratton	- C Pro C School, Camp Borden
Pte	DJ	Davies	- HMCS Stadacona, Halifax
Pte	IA	Mason	- Camp Gagetown

AW2	HL	Brooker	- RCAF Stn Summerside
AW2	IM	Chekaluk	- RCAF Stn St Jean
AW2	FW	English	- RCAF Stn St Jean
AW2	CM	Fraser	- No 6 RD, Trenton
AW2	MA	Koch	- RCAF Stn St Jean
AW2	MTV	Lapointe	- RCAF Stn St Jean
AW2	SJ	McMillan	- RCAF Stn St Denis
AW2	DJM	McNichol	- RCAF Stn Rockcliffe
AW2	MY	Smith	- RCAF Stn Comox
AW2	JM	Stangowitz	- RCAF Stn Cold Lake
AW2	SM	Thiele	- RCAF Stn St Hubert
AW1	DA	Turner	- RCAF Stn Senneterre

RELEASES AND RETIREMENTS

The following RCDC and RCAF Airwomen personnel have retired or taken their releases from the Corps:

Lt Col	WR	Cunningham	- (See 12 Coy News)
Cpl	ME	Jensen	- Dental Assistant at 4 (F) Wing Baden-Soellingen, Germany
LAW	TL	Hillier	- Dental Assistant, RCAF Stn Cold Lake
AW1	KY	Keddy	- Dental Assistant, RCAF Stn Summerside
AW1	ME	Lockerer	- Dental Assistant, RCAF Stn Trenton

POSTINGS

The following Corps personnel and Airwomen have been posted since the last issue of the Quarterly:

Major CGB Grant	-	to 1 PD Halifax from HMCS Cape Scott
Major J McGaughey	-	to HMC Dockyard from HMCS Bonaventure
Major AG Taylor	-	to HMCS Bonaventure from HMC Dockyard
Capt PJJ Coulombe	-	to Ft Henry 4 Fd Dent Coy from RCAF Stn Clinton
Capt JLY Cyrenne	-	to RMC from Cdn Forces Hospital Kingston
Capt LA Reynolds	-	to RCAF Stn Clinton from 13 PD Ottawa
Capt J Vincent	-	to Montreal, from Goose Bay
Capt JFA Marcil	-	to St Jean from Montreal
Ssgt MM Fediuk	-	to RCAF Stn Cold Lake from 14 Coy
Sgt JRA deBlois	-	to RCAF Stn Goose Bay from 6 RD Trenton
Sgt WH Fougere	-	to HMCS Cape Scott from HMC Dockyard
Sgt JA Gravelle	-	to RCAF Stn Downsview from 7 PD London (call-out)
Sgt FG Grundy	-	to HMC Dockyard from HMCS Cape Scott
Sgt DT Murley	-	to HMCS Stadacona from HMCS Cape Scott
Sgt HEW Reid	-	to 7 PD London from CBUME
Sgt EL Schell	-	to CBUME from 12 Coy
Sgt VH Shaw	-	to 4 Fd Dent Coy from 11 Coy
Sgt EV Tanner	-	to HMCS Stadacona from HMCS Cape Scott
Cpl WE Bussell	-	to 14 Coy from 7 PD London
Cpl JG MacPhee	-	to AG Br/DGDS Procurement Section
Cpl AL Strub	-	to CBUME from AG Br/DGDS Procurement Section
Pte RL Geddes	-	to HMCS Cornwallis from 1 DED
Pte JR Powell	-	to 1 Clinic AFHQ Ottawa
Pte CstC Sabine-Paisley	-	to 1 Clinic AFHQ from RCAF Stn Downsview
Pte RE Thompson	-	to RCAF Stn St Jean from RCAF Stn Lac St Denis
LAW AC Perrier	-	to RCAF Stn St Hubert from RCAF Stn Trenton

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TRAINING

During the period since 1 Nov 61, Corps personnel attended a variety of courses as listed hereunder:

University Courses

University of Alberta

Maj TD Cobb Maj IAC MacDonald)	-	Oral Diagnosis, Pathology and Surgery	6-9 Nov 61
Maj RJK Pyne	-	Oral Roentgenology	20-22 Nov 61

University of Michigan

Maj WH Murray	-	Endodontics	27 Nov - 8 Dec 61
Maj DE McDermott	-	Minor Oral Surgery	27 Nov - 8 Dec 61
Lt Col OW Crummey	-	Complete Dentures	8 Jan - 19 Jan 62

Courses - US Service Schools

US Naval Dental School - Bethesda, Md

Major WH Carter	-	Periodontia	10 Jan 62 (7 weeks)
Major JMA Donely	-	Crown & Bridge	10 Jan 62 (7 weeks)
Major IW Susser	-	Oral Surgery	10 Jan 62 (7 weeks)
Major TC Gaudet) Major AL Kelland)	-	Partial Dentures	8 - 12 Jan 62

Ent Air Force Base - Colorado Springs

Maj JA Lauziere	-	Oral Surgery	6 Nov - 18 Nov 61

NBCW Courses

CFMSTC - Camp Borden

Lt Col G MacDougall) Maj JD Bourque) Capt JSE Doiron)	-	Medical-Dental Officers NBCW	27 Nov - 8 Dec 61
Maj JI Gordon) Capt JT Marshall) Capt GC Travis)	-	Medical-Dental Officers NBCW	8 Jan - 19 Jan 62

Canadian Civil Defence College, Arnprior

Capt CA Casterton	-	Staff Course (Orientation and Operations)	13 Nov - 24 Nov 61

Sr NCO Course - RCASC School, Camp Borden

Cpl AH Green	Cpl EA Jermain	Cpl DT Moran
Cpl HD Wagstaff	Cpl RG Brighty	Cpl WR Dowell
Cpl P Fox	Cpl AW Hussey	

Jr NCO Course - Commands

A/Cpl G Dancer	Pte A Pink
Pte RH Stenabaugh	Pte CStC Sabine-Paisley
A/Cpl CVS Forsythe	

RCDC School Courses

Officers' Casualty Care and Officers' Clinical - 15 Jan - 16 Feb 62

Front Row - L to R: Maj ED Fraser, Maj CGB Grant, Maj WR Thompson (Instructor), Maj RE Dyer, Maj LA Richardson, Maj SW Muller

Back Row - L to R: *Maj MJ Albinati, Maj JG Andrews, Maj JM Smith, Maj LR Pierce, Lt Col GE Windsor, *Maj GL Locke, Maj G Kuttas USA (DC).

*These Militia Dental Officers are attending the Casualty Care Course only.

The casualty "patient" is "Mr. Disaster"

DT Lab Gp 1 - 15 Jan (20 weeks)

Front Row - L to R: Cpl JRM Chayer, Cpl A Schuh, Cpl JWW Broomfield, Cpl A Pink

Back Row - L to R: Instructor WO 2 EB Morse, Cpl B Morrissette

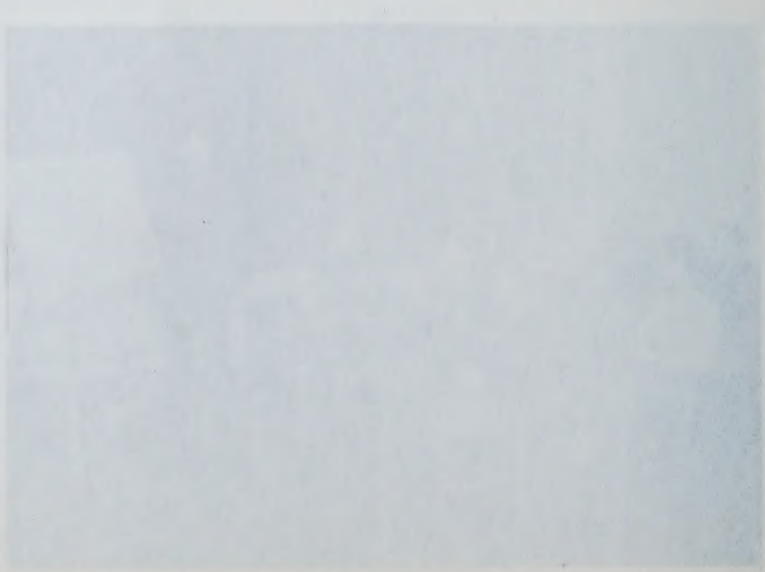
DT Cl Gp 3 - 15 Jan 62 (24 weeks)

Front Row - L to R: Sgt JAR Shields, Sgt AS Field, Sgt VR Kidd

Second Row - L to R: Miss EC Whebell, Miss IA Coulter, Sgt MP Foley

Third Row - L to R: Sgt JH Sadler, Sgt SE Robertson

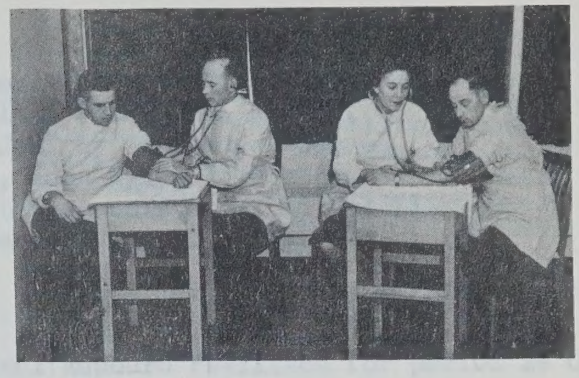
Org & Adm Instructor - Capt CA Casterton



Scaling Techniques

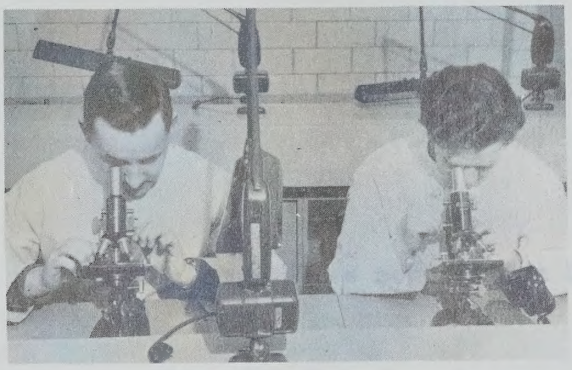
L to R: Maj JL Craig, Miss IA Coulter, Sgt JH Sadler

Casualty Aid Training



L to R: Sgt JAR Shields, Sgt SE Robertson, Miss EC Whebell, Sgt AS Field

Micro-Biological Studies



L to R: Sgt VR Kidd, Sgt MP Foley

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VITAL STATISTICS

THE RCDC SCHOOL

Births

Major and Mrs JM Smith, a son, James William Christopher, 20 Dec 61.
Major and Mrs JJN Wright, a daughter, Tamara Lynn, 5 Dec 61.
WO2 and Mrs EC Carpenter, a son, Richard Ernest, 24 Sep 61.
S sgt and Mrs JR Savoie, a son, Joseph Pierre, 8 Nov 61.
Sgt and Mrs M Beauvais, a daughter, Helen Marie Valeda, 5 Sep 61.
Sgt and Mrs ES Knoll, a daughter, Barbara Aileen, 29 Sep 61.

Hospital

WO 2 EC Carpenter was released from Camp Borden Hospital on 3 Nov 61 after a long bout with infectious hepatitis.

WO 2 EB Morse is now on sick leave and a very strict diet after five weeks in the Camp Hospital with "ticker" trouble.

Sgt G Jennings after two weeks in Toronto Military Hospital is attending regular physiotherapy clinics trying to give a stiff finger the bends.

NO 11 DENT COY

Births

Major and Mrs MP Quinn, a daughter, Patricia Michelle, 19 Sep 61.
Sgt and Mrs WJ Arnsby, a son, Walter Joseph, 14 Nov 61.
Major and Mrs WK Dickie, a son, Jeffrey Sanford, 6 Dec 61.
WO 2 and Mrs VO Blackmore, a son, John Kyle, 14 Nov 61.
Sgt and Mrs NC Petersen, a daughter, Lenore Anne, 18 Dec 61.
Pte and Mrs WW Webster, a son, Warren Randall, 4 Oct 61

Hospital

WO 2 RG Peebles admitted to Colonel Mewburn Pavillion for period 19 Oct to 27 Oct 61.

WO 2 AG Ponton admitted to Colonel Belcher Hospital for period 3 Oct to 6 Oct 61.

Sgt V Krymlak admitted to RCAF Station Namao Infirmary on 23 Dec 61.

Marriages

AW2 LJP Tudge married to LAC TG Travena.

NO 12 DENT COY

Births

Captain and Mrs DS Campbell, a son, Gordon Douglas, 10 Oct 61.

Hospital

S sgt JS Wentzell spent a few days in hospital as a result of an accident in which a bone in his ankle was chipped.

NO 13 DENT COY

Births

Capt and Mrs JJ Mitchinson, a daughter, Janine Rae, 16 Oct 61.
Capt and Mrs EG Baird, a son, Andrew Craig, 29 Oct 61.

Hospital

Capt GR Myles, 11 - 13 Oct 61.
Sgt WB Gilbert, 18 - 21 Dec 61.
Cpl JRE Lalonde, 14 Nov 61 -

Marriages

LAW AC Hughes married 4 Nov 61 to LAC RD Perrier.
LAW D Wierelejchyk married 4 Jan 61 to LAC BA Ellis.
AW1 ME Reddy married 7 Oct 61 to RCAF Cpl JD Locherer.
AW1 CMR Barbor married 9 Dec 61 to AC1 LN Lutz.

NO 14 DENT COY

Hospital

WO 2 JR Card was admitted to Deer Lodge Hospital on 6 Nov 61 and discharged hospital on 10 Nov 61, re-admitted on 20 Nov 61 and discharged on 22 Nov 61.

L/Sgt GA Fogg was admitted to Deer Lodge Hospital on 14 Nov 61 and discharged on 28 Nov 61.

Pte DL Kerr was admitted to Camp Shilo Military Hospital on 9 Nov 61, transferred to Deer Lodge on 10 Nov 61 and discharged on 17 Nov 61.

Marriages

AW1 YML Fournier married to Mr G Boulianne.

NO 15 DENT COY

Births

Major and Mrs RA Fell, a daughter, Tamar, 27 Sep 61
Sgt and Mrs M Tremblay, a son, Joseph Daniel, 13 Oct 61.

Marriages

AW1 E Allan married 9 Dec 61 to Cpl DB Graham.

Hospital

S sgt Couture recently was admitted to Montreal Military Hospital for a rest following two mild coronary attacks. Latest report is that he is doing well.

Cpl Sprathoff recovered successfully from an ankle injury sustained while skiing.

Capt Vincent had a cyst successfully removed from his operating hand.

Cpl Pouliot suffered a broken right hand recently.

4 FD DENT COY

Births

Major and Mrs C Brown, a son, Richard, 10 Dec 61.
Capt and Mrs DJ MacPhee, a son, Donald Joseph, 16 Dec 61.

CDN DENT DET CBUME

Sgt John Christiansen was admitted to UNEF Hospital with a broken ankle on 17 Nov 61 and had his foot in a cast for the next three weeks.

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DIRECTORATE OF DENTAL SERVICES NEWS

Annual Christmas Party

The annual Directorate Christmas Party was held on 15 Dec 61 at the HMCS Carleton Chief's and PO's Mess. In addition to those from the Directorate, personnel from the AFHQ, Rockcliffe and Uplands clinics attended. We were pleased and honoured to have Brig EM Wansbrough and Col CBH Climo attend and also welcomed Capt Swanson and Tech Sgt Reid of the USAF detachment stationed in Ottawa.

After the usual festive refreshments, Brig KM Baird thanked all personnel present for their co-operation and efforts during the year of '61 and expressed on behalf of the Ottawa area dental officers his wish for a happy and prosperous New Year to all ranks. WO 1 Jones replied to the Director's speech and thanked the officers for their consideration in providing a most enjoyable evening for all the ORs and civilian employees present.

DGDS to Toronto and Camp Borden

Brig Baird attended a meeting of the Editorial Board of Oral Health in Toronto on 24 Jan 62. From there, he proceeded to The RCDC School to inspect the facilities and personnel on staff and to talk to candidates attending the Officers' Clinical, DT Cl Gp 3 and DT Lab Gp 1 Courses which were in progress at the time.

Lt Col Hillier Attends Meeting of CDA Council on Public Health

Lt Col Hillier represented the DGDS at the 1962 Meeting of the CDA Council on Public Health held in Toronto 24-25 Jan 62. This was the first meeting of the Council to which a member of the RCDC was invited.

Curling

Members of the Directorate staff successfully met the challenge of a rink composed of RCDC officers attached to RCAF clinics in the Ottawa area on 28 Dec 61. The score will not be mentioned here as it might prove embarrassing to Maj Sills who is the Uplands Curling Club president but the members of each team comprised the following:

Winning Team			Other Team		
Maj AW Brusso	-	Skip	Capt CG Travis	-	Skip
Brig KM Baird	-	Vice Skip	Maj PS Sills	-	Vice Skip
Col IAL Millar	-	2nd	Maj JMA Donely	-	2nd
Lt Col DH Hillier	-	Lead	F/L W Carss	-	Lead (substitute for Maj AG Andrews)

In the Provincial playdowns for the Governor General's Trophy, Maj Brusso, a member of the Ottawa Granite Club Team, reached the quarter finals at Oshawa, Ont on 26 Jan 62.

Physical Fitness

In keeping with the physical fitness programme at AHQ, all ranks at this Directorate commenced their 5BX on 22 Jan 62. It has been noted of late that a new subject has been introduced into the coffee-break conversations - "To what level of Chart One have you progressed?"

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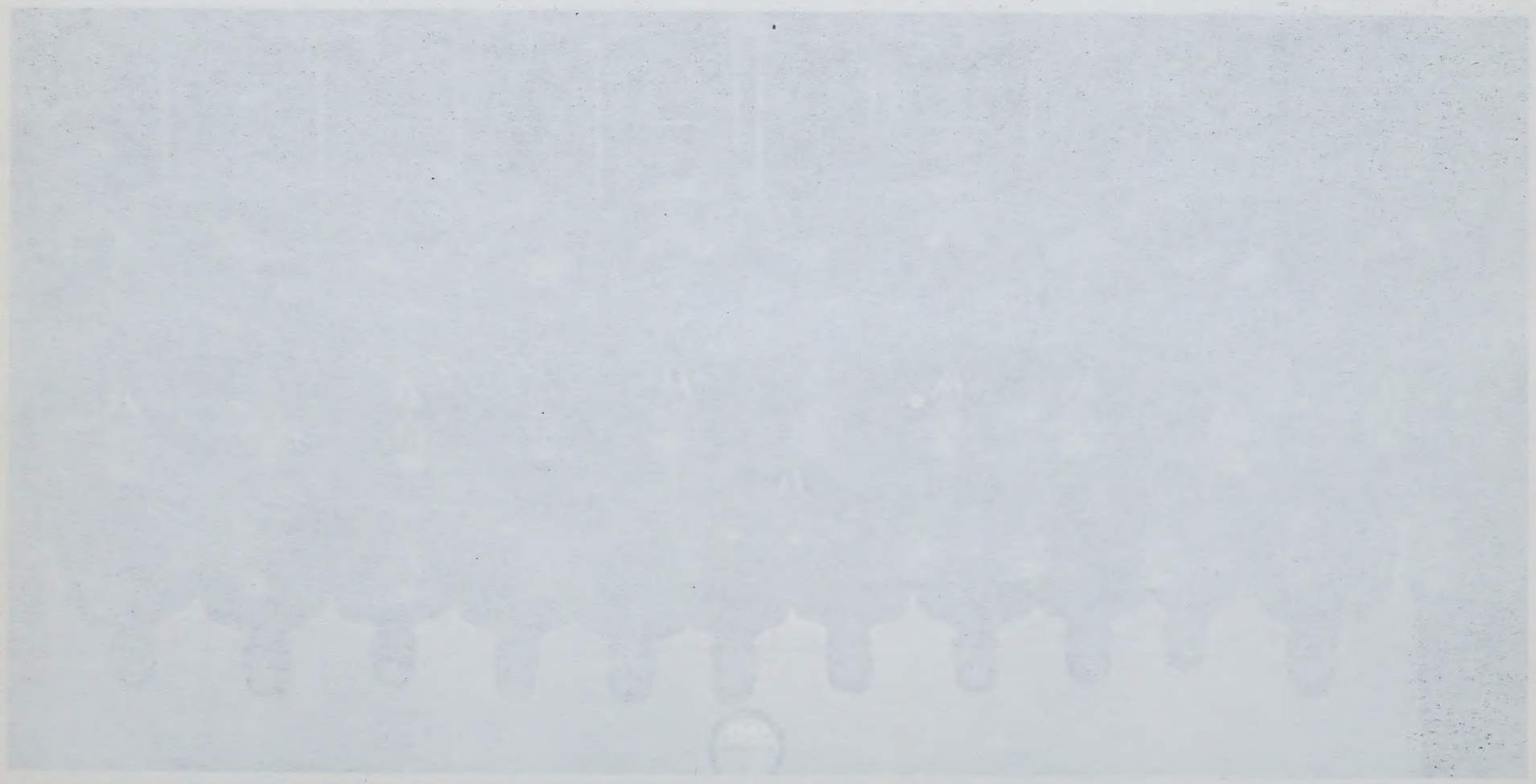
THE RCDC SCHOOL STAFF - 1961

Front Row - L to R: Capt CA Casterton, Maj JL Craig, Maj WR Thompson, Lt Col G MacDougall, Lt Col SG Bagnall, Col CE Purdy, Cdr RR Troxell (USN - DC), Maj JJN Wright, Maj JM Smith, Capt A Van Ryssel

Middle Row - L to R: Pte Johnson RB, Sgt Lowery RJ, Sgt Sadler JH, S sgt Bradley GEC, WO 2 Batten TL, LAW Giacobbo JA, WO 2 Jones JM, Sgt Jennings GR, Sgt Playford DB, Sgt Beauvais M, Cpl Jackson WA

Back Row - L to R: WO 2 Jackson TM, Cpl Walker RS, Cpl Chamberlain H, Sgt Knoll ES, WO 2 Bilbey HC, Sgt Libby GKW, S sgt Savoie JR, WO 2 Carpenter EC, Pte Deloughery TJ, WO 2 Hall RWM, Sgt Semple AF

Missing - Capt DG Cartwright, WO 2 Morse EB



NO 1 DENT EQPT DEP NEWS

13 Coy Visitors

Col AC Leman and Capt IP Hunter paid a visit to the Depot while in Camp Petawawa to inspect No 3 Dental Clinic.

Depot Staff Members Visit other Units

Major JW Fletcher attended the Corps Conference in Ottawa in December.

Lt EA Church, WO 1 WD Morris and S sgt JW Hutchinson visited clinics in the Ottawa area at various times to repair dental equipment.

Maj Fletcher Curling Club President

Major JW Fletcher is busy these days in his capacity as first President of the new Camp Petawawa Curling Club which was opened by Colonel Cathcart, Commander, Camp Petawawa, on 24 Nov 61.

S sgt Davison Curling Winner

S sgt AF Davison gladly accepted some of the silverware distributed in a recent mixed Curling Club Bonspiel.

Xmas Parties

Members of the Depot and No 3 Clinic held a very successful Christmas Party in the Junior Ranks Club on 9 Dec. On 16 Dec another Xmas party was held in the Medical Depot canteen for the children complete with Santa Claus. All 37 children went home happy, at least for another day.

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NO 11 DENT COY NEWS

Duty Trips and Visits

Many members of the Unit were employed on temporary duty during the period covered by this issue of the Quarterly:

Col Kearney logged many miles in November and December visiting clinics and QM Stores in Calgary, clinics at RCAF Stations Cold Lake and Namao. He also attended the Corps Conference in Ottawa and along with S sgt H Hodkinson and Sgt GF Keogh flew to RCN Radio Station Inuvik, NWT to provide treatment for RCN personnel and dependents during the period 6 - 17 Nov.

Capt JGB Dionne and Sgt MG Dean spent the first three weeks of November at RCAF Station Holberg providing dental treatment to RCAF personnel and their dependents.

Capt AG Garden and Sgt JAR Shields were more fortunate spending three weeks in and around San Francisco on a training cruise in November.

S sgt Conkey spent some time on equipment repair for clinics in the Edmonton area in October and did the same thing in the Vancouver and Victoria areas in late November.

WO 2 AJ Greco was employed at RCAF Station Cold Lake during October and November.

Cpl J Dion assisted at RCAF Station Namao in December while Cpl Dundas was on leave.

Miss Fogg spent two weeks relieving at RCAF Station Namao in the latter part of October while Cpl Dundas and AW2 Tudge were in hospital.

Cpl Schuh Winner in Pistol Meet

A very successful Pistol Meet was held on Saturday, 28 October, at the South Vancouver Island Rangers Range at Luxton, BC. Twenty-eight competitors vied for the 34 trophies and awards available. The most noticeable new-comer was Cpl Schuh who won one competition outright and was the high tyro in two others. Congratulations Corporal.

Cpl Schuh's results are as follows:

9 mm Pistol (open match) for Murdoch-Girard Trophy - 253 points, high tyro

.22 Pistol Tyro Match - Brock Whitney Trophy - 250 points, Winner.

Any centre-fire pistol (open) for G.T.C. Trophy - 229 points, high tyro.

Cpl Schuh used a Smith and Wesson 44 cal. magnum with a barrel length of 8 3/8". This gun was used in the big calibre open event. Other pistols that netted high scores were a 22 calibre High Standard Supermatic Match-Pistol and the Navy's 9 mm Browning High Power.

Cpl Schuh receiving the Brock Whitney High Tyro Trophy from Lieut CH Humble, RCN

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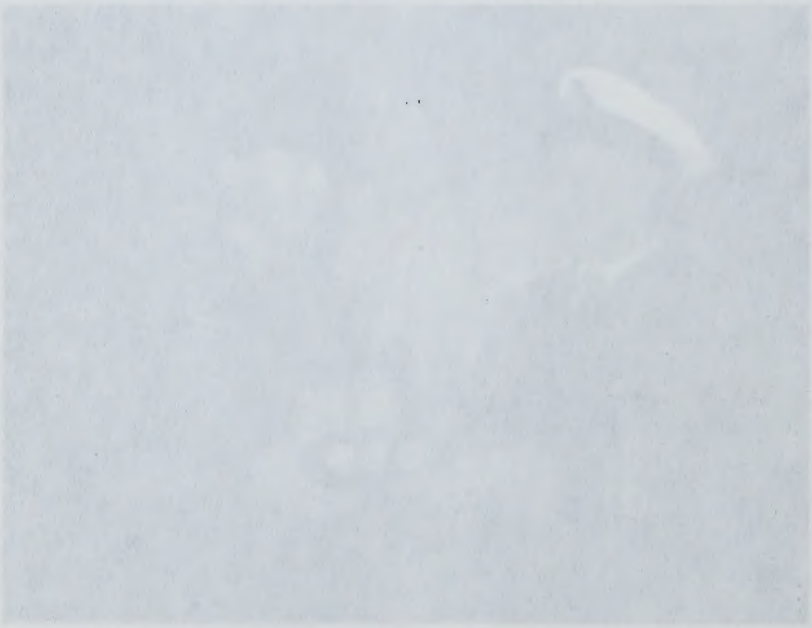

NO 12 DENT COY NEWS

Lt Col "Wyn" Cunningham Retires

Army Headquarters has announced the retirement of Lt Col Winston R Cunningham, Senior Clinician at HMCS Stadacona, Halifax.

Lt Col Cunningham was born in Elgin, Manitoba and received his early education at Souris Collegiate and was granted his DDS from the University of Toronto in 1934. He is married and has one daughter.

Commissioned as a Lieutenant, CDC in 1939, he served with No 10 and 5 Companies in Canada until October 1941 when he was promoted to Captain and proceeded to Hong Kong with Headquarters "C" Force. He was taken prisoner by the Japanese in December 1941 but continued to administer to Canadian Prisoners of War during his period of captivity, and was promoted Major in February 1944. He returned to Canada in October 1945 and served with 21, 22, 13 and 11 Dental Companies until December 1951 when he was posted to the Directorate of Dental Services, Army Headquarters. He was promoted to Lt Col in 1953 and posted overseas as Commanding Officer, No 35 Field Dental Unit in France. On his return to Canada in 1955 he was appointed senior operator, Camp Borden and assumed his present appointment in July 1959.

His posting to our Unit has proved to be a most pleasant one and all members wish him well on his retirement. It is our hope that he will continue his association with the Corps in a civilian capacity.

Holiday Season Parties

Major and Mrs J McGaughey and Capt and Mrs MAJ LaChapelle entertained the Halifax Area officers and their wives aboard HMCS Bonaventure during the holiday season.

Lt Col and Mrs WR Cunningham entertained the Halifax Area officers and their wives at a festive season party.

Colonel Roger to Sydney

Colonel Roger paid a liaison visit to Sydney NS to investigate the opening of two part-time clinics in that area.

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NO 13 DENT COY NEWS

Duty Trips and Visits

Col AC Leman attended the Unit Commanders' Conference in Ottawa 4-6 Dec 61.

The AOC ATCHQ, A/C RJ Lane accompanied by G/C DJ Williams, CO RCAF Station Trenton, inspected HQ 13 Coy and 15 Dental Clinic, Trenton the morning of 5 Dec 61.

The CDO and the four dental officers in the Trenton area attended the monthly dinner-clinical meeting at the Canadian Forces Hospital Kingston on 8 Nov 61. The speaker S/L GM Fitzgibbon, cardiologist at NDMC Ottawa, presented a most interesting and comprehensive address entitled "The Dentist and the Cardiac Patient". The meeting was well attended by the Meds, Dents and members of the EODA.

Capts GT Crossman and FW Lovely visited HQ 13 Coy enroute overseas by service aircraft. Cpl JG MacPhee was also a visitor on his return from CBUME by North Star. An invitation is extended to all Corps personnel to drop in for a visit when in this area.

Sports

Three dental teams are entered in RCAF Station Trenton bowling league, two in the mixed league and one in the men's. Sgt WB Gilbert is Captain of the clinic mixed team. Lt EI Tullis is Captain of Coy HQ mixed team. Cpl WL Wylie is Captain of the men's team in the Inter-Section league.

Mrs Mabel Riddell

Our sympathies are extended to WO 2 DW Riddell on the death of his wife, Mabel, at Trenton on 22 Jan 61. Funeral services were held in St John's Church, Cornwall on 25 Jan 62 with interment at Woodlawn Cemetery.

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NO 14 DENT COY NEWS

Bowling

Interest and competition continues to be keen in the Unit Bowling League. A pre-Christmas turkey roll was held on 15 Dec 61. Prizes were won by:

Mrs Muller, Mrs Janowski, Mrs Laurence, Mrs Young, Mrs Champoux, Mrs Cathcart, Capt Boulay, Mrs Nixon, and AW1 Fournier.

Curling

Many of the Unit's personnel are participating in the very popular game of curling this winter. While it is too early to predict results, some of the teams show promise of being finalists.

Exercise Tocsin B/61

This Unit participated in Exercise Tocsin B/61 during 13-14 Nov 61. Personnel of 14 Coy joined with the RCAMC to form No 1 Med Coy for the purpose of the Exercise.

Christmas Party

An enjoyable all ranks Christmas Party was held on Thursday 21 Dec 61 at the RCAF Station Winnipeg. All RCDC and associated personnel employed in the Winnipeg area attended.

Captains Boulay and Brogan Bereaved

On 21 Oct 61 Capt Boulay proceeded to St Hyacinth, Que to attend the funeral of his brother, the victim of a fatal highway accident and on 28 Nov 61 Capt Brogan attended the funeral of his brother who was killed in a hunting accident in Minto, NB.

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NO 15 DENT COY NEWS

Duty Trips and Visits

Lt Col Butler toured the northern clinics recently, visiting Quebec, Valcartier and Goose Bay.

Our clerks and Adm Offr have done an excellent job at TAHQ St Jerome with the AO being the first Camp Commandant as well as the last to do a tour of duty there.

Capt Parent proceeded on two weeks' TD in December from St Johns to Goose Bay.

Maj Gordon and AW1 Thibeault proceeded from St Hubert to Moisie for three weeks in December.

Special Events

Holiday Visitors

During the festive season, old friends paid a visit to the St Jean clinic. A warm welcome was extended to Major Bob Dyer, WO 2 Max Fisk and F/Sgt Pat Savage.

"Call-Outs"

Welcome is extended to Major AR Ramsay on "call-out" from the Reserves. Since his retirement from the RCDC(R) he has been employed as a Part V civilian dentist in the Montreal Area.

When's The Wedding?

We wish to congratulate AW1 Peck on her recent engagement. We understand that her ring is being prominently displayed these days.

Quebec Winter Carnival

The Quebec Winter Carnival is fast approaching and Major Jacques Durand reports much activity in ice palace and ice monument building. This carnival is quite an event and should be visited by anyone not glued to a wheelchair.

Unit Members Participate in Sports Programmes

The value of sports for the promotion of efficiency and longevity is fast becoming realized. Many of our members, not normally addicted to sports, have begun to take an active part in recreational activities sponsored by the Army and are beginning now to feel the benefit. These activities are, of course, in addition to 5BX.

Curling

This unit has some good curlers and others who are "coming along". Skip, "The Rocket" Fortin issues an open challenge from his clinic team to any other clinic and the RCDC School for a friendly game provided it is played on Quebec ice. After a late start at Goose Bay, Capt Fred Begin and Sgt Tom Hussey are hurling the rocks as though they were featherweights. Lt Col Butler continues to wield the rock effectively at a newly-formed private club out in the suburbs.

Skiing

Capt Harrison is again the Secretary-Treasurer and an active member of the Montreal Branch of the Canadian Army Ski Club. Chuck Johnston is also a member.

Bowling

Bowling has its share of players regularly involved:

"Good Old Lefty" Dennis at Goose Bay, Ed Moore at HQ and the boys from down under (St Jean).

Golf

Golf is still in the forefront of some members' minds as they take to the gym and drill hall practise nets.

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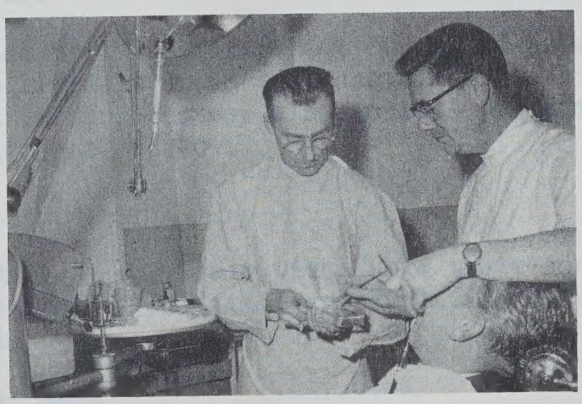
NO 35 FD DENT UNIT NEWS

Duty Trips and Visits

Lt Col Craigie and Capt DH Evans visited HQ USAREUR, Heidelberg on 21-22 Nov.

Major WH Harrington, WO 2 AG Cross and Sgt A Fox spent a month in England recently at the new clinic at CJS London and at 30 AMB Langar providing dental treatment. The accompanying photo shows Maj Harrington and WO 2 Cross at work in the new CJS clinic.



35 Fd European Dental Curling Champs

The first annual European Dental Challenge Bonspiel was held in Zweibrucken Germany on 25-26 Nov 61. Two rinks from 4 Fd Dent Coy and two from 35 Fd Dent Unit participated.

The rinks from 35 Fd showed mid-season form all the way and their ability to come through under pressure and in the clutch proved too much for the challengers. The rink composed of Capt Meisner, Maj Franklin, Maj Charman and Lt Col Craigie curled the 3-game round-robin series without a defeat in spite of tough opposition. A special mention is due Maj Charman and Sgt Rothwell for their hard work in caring for the curlers both on and off the ice. The following rinks attended:

4 Fd Dent Coy

1. Capt Coulombe, Capt Headley, Capt Kelly and Lt Col Evans
2. Sgt Hill, S sgt Bennett, Sgt Byers (RCAMC) and Sgt Cahill

35 Fd Dent Unit

1. Capt Meisner, Maj Franklin, Maj Charman and Lt Col Craigie
2. Sgt Marchand, Sgt Fox, WO 1 Loken and Sgt Roberts

Two suitable shields were produced for this occasion by RCDC ingenuity, each represented by a horse cut exactly in half. The appropriate shields were presented to the winners and losers, respectively.

Unit Conference

A conference attended by all dental officers of the unit was held at Air Division HQ, Metz on 3 and 4 Nov 61.

Lt Col Craigie Judges Beauty Contest

Lt Col Craigie acted as one of the judges at the annual "Miss Grey Cup - Europe" contest on 17 Nov 61. LAW Judy Bowes, Dental Assistant, was an unsuccessful "Western" candidate in the contest, representing 3 (F) Wing, Zweibrucken.

Grey Cup Europe 1961

"Grey Cup Europe 1961" again presented an exciting afternoon to Canadians (a bewildering one for French people). Complete with parade, cheerleaders, bands and Miss Grey Cup, the event got underway at 1230 hrs on 18 Nov. In the ensuing game, the Eastern team, under the capable coaching of Cpl Bill Parker, was victorious by a score of 28 to 13.

"Grey Cup Canada 1961" was broadcast "Loud and Clear" in Europe and personnel of 1 Air Division lived it up in the messes and clubs during and after the game. The expected, but delayed Western win provided Westerners with the opportunity to return the "needling" of 18 Nov.

HQ Xmas Party

Personnel at Unit HQ and their wives held their annual Christmas party on 21 Dec. An enjoyable evening of dancing, stimulating conversation and refreshments was enjoyed by all.

WO 1 Loken PMC Sergeants' Mess

WO 1 Charlie Loken has assumed the duties of PMC Sergeants' Mess at 1 Air Div HQ until 31 Mar 62.

Western Germany Armed Forces Dental Society

Majors CJ Sivell, ED Charman, AT Hinch and Capt JG Boucher attended a Clinical Pathological Conference of the Western Germany Armed Forces Dental Society at Landstuhl, Germany on 13 Oct.

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4 DA Dent Det

1. Capt Coulombe, Cent Bendley, Capt Kelly and Lt Col Evans
2. Sgt Hill, S sgt Bennett, Sgt Byers (RCAMC) and Sgt Cahill

29 FD Dent Unit

1. Capt Belanger, Maj Franklin, Maj Charron and Lt Col Crelgie
2. Sgt Barchard, Sgt Fox, WO I Loken and Sgt Roberts

Two suitable medals were produced for this occasion by NDHQ Ingenuity, each represented by a horse cut exactly in half. The appropriate medals were presented to the winners and loosers, respectively.

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Western Germany Armed Forces Dental Society

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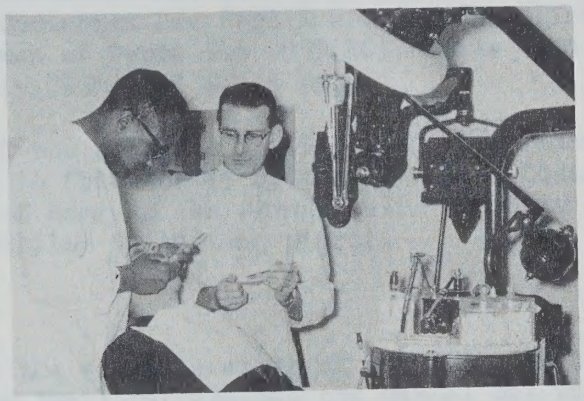
NO 4 FD DENT COY NEWS

New Clinic Opens

A new permanent type clinic was opened at Fort Beausejour on 30 Oct. The accompanying photograph shows Capt RH Headley and Cpl EJ Lansey, who comprise the staff of the new clinic, busy treating a patient.



Unit Personnel Participate in NATO Exercise

A dental sub-section consisting of Capt DJ MacPhee and Sgt MO MacDonald accompanied the Brigade umpiring staff on "Spearpoint" a ten-day NATO Exercise.

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DENTAL DETACHMENT CBUME NEWS

UN Day Parade

On 24 Oct all ranks attended the UN Day Ceremonies at Gaza with Cpl Ed Giles representing the Detachment in the General Salute and march past. All contingents in UNEF were represented in the parade which was held on the border between the Gaza Strip and Israel.

Visit of Canadian Ambassador

On 27 Oct Mr. R.A.D. Ford, accompanied by Mrs Ford and Group Captain Langstaff, Aide-de-Camp visited CBUME and were guests of honour at the Officers' Mess. Mrs Ford and G/C Langstaff inspected the dental clinic.

Medal Parade

During the month of December the following personnel were presented with the UNEF Medal for service in the Middle East; Major Small, Capt Bunt, Capt Arpin, Sgt Christiansen, Sgt Drawe and Sgt Boulanger.

Farewell Party

On 10 Dec this detachment held a party for Sgt Harvey Reid and Cpl Joe MacPhee on the happy occasion of their imminent return to Canada. Major Small made a short speech outlining the high points of their tour with CBUME and on behalf of all personnel wished them Godspeed and good luck in their new postings.

Leave

During the present leave period the following personnel spent a week's leave at the Leave Center in Cairo: Capt Bunt, Sgts Reid and Martell, Cpls Giles and MacPhee. During the same period, Major Small, Capt Bunt and Capt Arpin went on a four-day tour of Jerusalem.

Christmas Festivities

During the Christmas-New Year's season numerous parties were held by messes in CBUME. On Christmas Day Capt Bunt, Sgt Christiansen and Sgt Drawe served dinner to the men of Recce Sqn LdSH(RC), while Capt Arpin, Sgt Schell and Sgt Boulanger served in CBUME "A" Men's Mess.

Highlight of the season's festivities was the decoration of several Christmas trees flown in from Norway by the Norwegian Contingent for the occasion. This brought a touch of home to the Canadians in the Gaza Strip, and brought to mind the fact that rotation is getting nearer.

Polar Bear Club

On 1 Jan 62 the annual meeting of the UNEF "Polar Bear Club" was held at Rafah Beach. Major Small represented the Dental Detachment and jumped (or was pushed) into the icy waters of the Mediterranean. Afterwards through chattering teeth he reported that it wasn't any worse than doing the same thing in January in Lake Ontario.

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TRELFORD TROPHY PRESENTATION

This photograph, taken in April 1961, pictures Col WG Trelford presenting his trophy to Lt Col AJ Harris, Commanding Officer, No 55 Dental Unit (M). This Unit was the 1960 winner of the Trelford Trophy, given to the runner-up in the General Efficiency Competition for Militia Dental Units.

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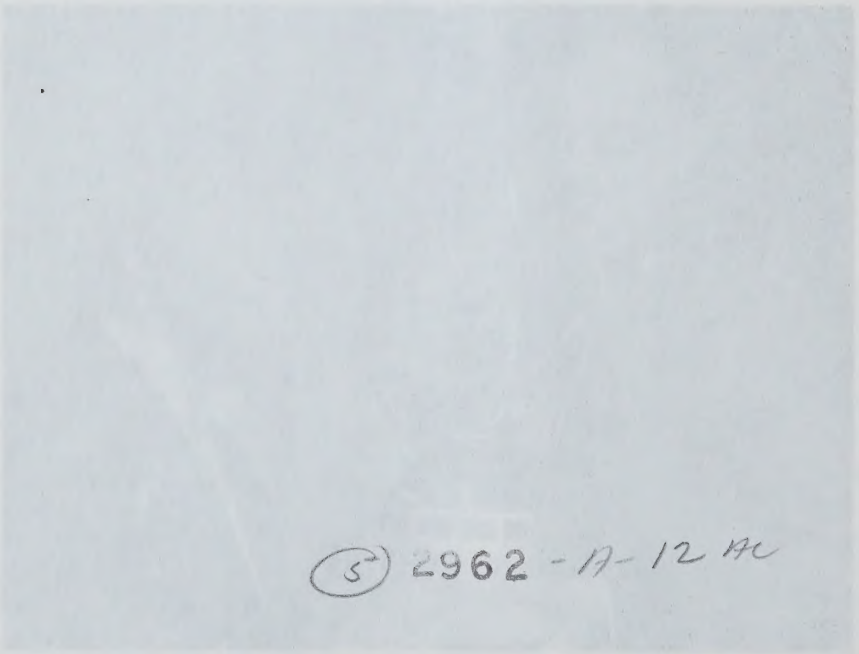

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